First Annual Report

Christian Reformed World Relief Committee (CRWRC)

Bangladesh
Dhaka, Netrokona, Panchagar

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BCM	Bengal Creative Media
CCI	Community Capacity Indicators
CHV	Community Health Volunteer
C-IMCI	Community/Household Integrated Management of Childhood Illness
CRWRC	Christian Reformed World Relief Committee
CSP	Child Survival Project
CSSA	Child Survival Sustainability Assessment
CSTS+	Child Survival Technical Support Plus Project
CWI	Concern Worldwide, Inc.
DIP	Detailed Implementation Plan
EPI	Expanded Program on Immunization
FGD	Focus Group Discussion
GOB	Government of Bangladesh
HBLSS	Home-Based Life Saving Skills
HFA	Health Facilities Assessment
HIV	Human Immunodeficiency Virus
ICDDR,B	International Center for Diarrheal Disease Research in Bangladesh
KPC	Knowledge, Practices, and Coverage survey
LAMB	Lutheran Aid to Medicine in Bangladesh
MOH	Ministry of Health
NGO	Non-Governmental Organization
OCI	Organizational Capacity Indicators
ORS	Oral Rehydration Solution
PD	Positive Deviance
PLA	Participatory Learning and Action
PRA	Participatory Rural Appraisal
PVO	Private Voluntary Organization
TBA	Traditional Birth Attendant
TTBA	Trained Traditional Birth Attendant
TFD	Theatre for Development
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	Women of Reproductive Age

I. INTRODUCTION

The Christian Reformed World Relief Committee (CRWRC) received funding from the USAID Child Survival and Health Grants Program in the Entry category for a five-year program in Bangladesh that seeks to achieve and sustain improved health and rates of survival for children under age five and women of reproductive age.

The program targets two rural districts (Panchagor and Netrokona) and one urban district (Dhaka) in Bangladesh where rates of under five-child mortality (88 deaths/1,000 live births) and maternal mortality (322 deaths/100,000 live births) are very high (NIPORT, 2003; NIPORT, 2005). The six strategic objectives for CRWRC's Child Survival Project (CSP) are: 1) improve maternal and neonatal care; 2) prevent and properly treat diarrheal disease; 3) detect ARI and make appropriate referrals; 4) improve child nutrition; 5) reduce mortality and morbidity from vaccine preventable diseases; and 6) increase awareness about HIV/AIDS. In order to achieve these objectives, CRWRC works with three partner organizations: Pari (Netrokona), Sathi (Dhaka) and Supoth (Panchagor). Over the life of the project, CRWRC and its partners hope to directly benefit 5,072 children under five and 11,468 women of reproductive age (WRA).

CRWRC incorporated the strategic objectives into the three components of the Community/Household Integrated Management of Childhood Illness (C-IMCI) resulting in the following key intervention activities:

1) Improve networking with health facilities in order to refer complicated pregnancies and severe childhood illnesses.
2) Increase the quality and availability of pre-natal, natal and post-natal care through training of traditional birth attendants (TBAs).
3) Promote key family practices critical for child health and nutrition through training community health volunteers (CHVs) and forming primary groups.

This report describes the intervention activities that have been implemented and the modifications made during the first year of the CRWRC Child Survival Project (September 30, 2004 and September 30, 2005).

II. ANNUAL REPORT

A. Major Accomplishments

Preparation for Implementation

During October 2004, CRWRC hired new staff and assisted its three partner organizations in hiring new staff. All three partners established a relationship with the District Civil Surgeons in Dhaka, Panchagor and Netrokona, as well as the Thana Health Officers, the Union Chairmen and the Thana Health Complex, through the health coordinators in each working area. These relationships have helped CRWRC partners to have access to vitamin A, iron, and anthelmintics for distribution to the communities

as well as be involved in the vaccination programs in each working area. All three coordinators also participate in the monthly district-wide health meetings conducted by the Civil Surgeons in each of the districts.

In November and December 2004, CRWRC trained partner staff in qualitative and quantitative survey methodologies including Participatory Rural Appraisal (PRA), Focus Group Discussions (FGDs), and Knowledge, Practices, and Coverage (KPC) surveys. Following these workshops CRWRC and its partners developed and implemented a comprehensive baseline study in all three working areas. The baseline data was used to develop the detailed implementation plan (DIP), the final copy of which was submitted to USAID on July 29, 2005. Following the DIP review, CRWRC conducted a Health Facilities Assessment (HFA) in all three working areas. This assessment was analyzed to help determine the most appropriate health facilities in the area for referring complicated pregnancies and severe childhood illnesses. A list of the major activities during the preparation for implementation and the status of each activity appear in Table 1 below.

Table1: Major Accomplishments During Preparation for Implementation

Preparation for Implementation	Key Activities	Status of Activities	Comments
Human Resources	▪ Hire CRWRC staff (2), health coordinators (3), and field staff (16) ▪ Orient new staff	Complete Complete	19 field staff hired in the three projects (1 Coordinator and 4 Health Animators in Sathi, 1 Coordinator and 6 Health Animators in Pari and 1 Coordinator and 6 Health Animators in Supoth).
Stakeholder Participation	▪ Network with local health officials, other NGOs, and government offices ▪ Dissemination meetings with local stakeholders (3)	On going Complete	Networking began within the first 2 months of the project and continues to strengthen. In Panchagor, the Civil Surgeon has given the CSP staff the task for distribution of iron, vitamin A and deworming medicine. In the other two areas, this distribution is coordinated with the local Government.
Baseline Survey	▪ Qualitative surveys (PRA, FGDs) ▪ Quantitative surveys (KPC)	Complete Complete	20 staff from the three projects were trained to conduct surveys. Staff carried out surveys and analyzed all data.
Detailed Implementation Plan (DIP)	▪ Draft DIP ▪ Review DIP with USAID ▪ Revise DIP	Complete Complete Complete	DIP work plans have been translated into Bangla for the Coordinators and Health Animators. They now each have a copy and review on a monthly basis.
Health Facilities Assessment Survey	▪ Train staff in facilities survey work ▪ Conduct survey and analyze results ▪ Develop referral charts for CHVs and TBAs	Complete Complete Complete	CHVs and TBAs have a referral system in place and cards in Bangla outlining best referral services for specific types of cases.

Project Objectives

The major accomplishments of CRWRC concerning the project objectives included the selection and training of traditional birth attendants and community health volunteers as well as the formation of primary groups and adolescent groups. A list of the major activities accomplished pertaining to the project objectives and the status of each activity appears in Table 3.

Training of Traditional Birth Attendants

All three partners achieved or exceeded their targets for training TBAs in the first year with the exception of Supoth, whose trainings are slightly delayed due to a scheduling conflict. The TBAs were selected and trained per the requirements described in the DIP. In Dhaka, 32 TBAs were trained by Radda Barnen (Save the Children, Denmark); in Netrokona, 25 TBAs were trained by Joyramkura Hospital; and in Panchagor, 25 TBAs will be trained by LAMB Hospital on October 29, 2005. The training is both skills and knowledge based and includes pre and post workshop testing of the TBAs. Although the baseline surveys showed that some mothers would have difficulty accepting the newly trained TBAs, the trained traditional birth attendants (TTBAs) are becoming widely accepted in the communities. This is most likely attributed to the familiarity of the TTBAs with the community and their involvement in the community. As these TTBAs become more involved in the lives of young women and mothers, the pregnant women in the community will more likely choose the TTBAs over the non-trained TBAs to deliver their children. TTBAs are also responsible for making referrals, ensuring tetanus immunization, iron supplementation, deworming medication, and postnatal vitamin A supplementation. Of 115 deliveries in this last quarter, 98 were delivered by the trained TBAs and 17 were referred by them to appropriate facilities. As the TTBAs begin to use reporting cards, the outcomes of each delivery will be known as well.

Training of Community Health Volunteers

All three partners achieved or exceeded their targets for training CHVs in the first year with the exception of Sathi, who plans on training CHVs on October 29, 2005. The CHVs were selected and trained per the requirements described in the DIP. In Dhaka, 75 CHVs were selected and 12 Sathi staff received a training of trainers course on maternal and child health issues by Radda Barnen. These 12 staff will train all of the CHVs in the Sathi working areas in October and November 2005. In Netrokona, 35 CHVs were trained by Joyramkura Hospital, and in Panchagor, 25 CHVs were trained by LAMB Hospital. These CHVs are responsible for health education regarding nutrition, breastfeeding, childhood illnesses, vaccinations, vitamin A supplementation, deworming, and sanitation.

In addition to the work of the CHVs, CRWRC conducted a zinc awareness meeting in Panchagor for village doctors, private practitioners, and pharmacists in the CSP working areas. A total of 38 people participated in the one-day workshop where they learned about the benefits of using zinc for treatment of diarrhea and acute respiratory infections (ARI) as well as the protocol for using zinc to treat a sick child. These workshops will

also be held in the CSP working areas in Dhaka and Netrokona. Two Dhaka workshops will be completed in October 2005 and one Netrokona workshop in November 2005. Due to the excitement about these workshops, CRWRC plans to hold bi-annual meetings with the same target group of individuals (community-based providers/people of influence) on best practices for maternal and child health-related issues.

Formation of Primary Groups and Adolescent Groups

One of the keys to success of CRWRC's Child Survival Project is the formation of primary groups and adolescent groups. Primary groups are the foundation of development activities for CRWRC. The primary groups involved in the CSP were formed following the PRA in December 2004. The primary groups are separate for men and women and include 15-25 people. A collection of primary groups (male and female) in one union form a central committee, which is gender mixed. Several central committees in one Thana form the Thana Federation. The goal for the Thana Federation, and the associated primary groups, is to become independent and have a lasting impact on their members and on the broader community. All of CRWRC's CSP activities are targeted towards the members of the primary groups with the hope that the primary groups will have a greater impact on the broader community. Members from each primary group are also involved in a technical team. The Child Survival Project focuses on the health technical team of which the CHVs and TTBAs are a part. Annex 1 depicts the relationships between these different groups and the broader community. Adolescent groups were also formed with the view that these young girls and boys will one day become mothers and fathers; wives and husbands. Therefore, the same maternal and child health messages are taught to these groups as the primary groups.

As a result of the training of TBAs and CHVs as well as the formation of primary groups in the communities, CRWRC has noticed many positive changes in maternal and child health compared to the baseline measurements (Annex 2). Some of the highlights include a dramatic increase in all three areas in the number of mothers who offered their children more fluids and food during diarrheal disease. Also, the availability of soap for handwashing increased significantly for both Netrokona and Dhaka. Netrokona and Dhaka also showed an increase in the number of mothers who could report at least two child danger signs or symptoms. Lastly, the number of mothers who fed their 6 – 9 month old infants semi-solid or family foods in the last 24 hours increased greatly. There were many indicators that increased in some project areas, but not in others such as prenatal care coverage, ORS use during diarrhea, and ARI care seeking. There were also some indicators that decreased in all three project areas including tetanus toxoid injections for pregnant mothers and zinc use during diarrhea. It is still difficult to say that the changes detected after the first nutritional surveillance survey were due to the CRWRC program interventions. There was little time to begin intervention activities since the first year focused on conducting a baseline survey, preparing the DIP, forming new primary groups, and training TBAs and CHVs. However, it is important to note the major trends in CRWRC project interventions. Some of the indicators in the monitoring and evaluation plan were not measured during the nutritional surveillance, but these indicators will be measured at midterm and at the end of the project. CRWRC expects to see continuous positive change in maternal and neonatal health, morbidity due to

diarrhea and ARI, child nutrition, immunizations and knowledge about HIV/AIDS over the next four years.

Table 2 below shows the number of groups that have been formed in each working area to date. It also shows the number of children under five, WRA, men and adolescents that are a part of these groups. All of the targets were achieved or exceeded with the exception of Sathi's work with children under five in Dhaka.

Table 2: Primary Groups and Adolescent Groups and the Respective Participants in the Child Survival Project Working Areas.

Particulars		Dhaka		Netrokona		Panchagar		TOTAL	
		Actual	Target	Actual	Target	Actual	Target	Actual	Target
Primary Groups	Women's	129	129	35	35	87	84	251	248
	Men's	58	NA	NA	NA	22	NA	80	NA
Primary Group Members	Women	2355	2280	567	560	1710	1650	4632	4490
	Men	998	NA	NA	NA	443	NA	1441	NA
Adolescent Groups	Girls	31	32	4	4	12	12	47	48
	Boys	18	18	2	2	10	10	30	30
Adolescent Group Members	Girls	346	360	75	75	258	250	679	685
	Boys	211	200	42	42	224	200	477	442
Number of children under 5		1091	1350	763	654	1276	1150	3130	3154

Table 3: Major Accomplishments in Project Objectives

Project Objectives	Key Activities	Status of Activities	Comments
Improve Maternal and Neonatal Care	▪ Select TBAs to be trained ▪ Train TBAs ▪ Ensure TBAs are performing their duties according to the DIP.	Complete In progress On going	Due to a scheduling conflict, Supoth will complete TBA training on October 29, 2005.
Prevent and Properly Treat Diarrheal Disease	▪ Select CHVs to be trained ▪ Train CHVs ▪ Ensure CHVs are performing their duties according to the DIP. ▪ Facilitate workshop on zinc for village doctors	Complete In progress On going In progress	Sathi will begin training CHVs on October 29, 2005. CHV supervision meetings held monthly.
Detect ARI and Make Appropriate Referrals	▪ Ensure CHVs are performing their duties according to the DIP.	On going	New recording books will document information on ARI and referrals.
Improve Child Nutrition	▪ Develop growth monitoring groups and ensure proper growth monitoring techniques ▪ Ensure CHVs are performing their duties according to the DIP.	Complete On going	Growth monitoring is now taking place monthly in each field. Many community children as well as children of group members are part of growth monitoring.
Reduce Mortality and Morbidity from Vaccine	▪ Coordinate with Government EPI program to achieve better coverage	Complete	Two vaccination campaigns occurred in this period.

Preventable Diseases	▪ Ensure performing their duties according to the DIP.	On going	Accurate records of vaccinations on going.
Increase Awareness of HIV/AIDS	▪ Ensure CHVs are performing their duties according to the DIP.	On going	Most HIV/AIDS education to date has focused on adolescent groups. Adult groups will start in November 2005.

Technical Interventions

During the course of the first year of implementation, there was one major technical strategy adopted and two major technical interventions applied. Based on feedback from the DIP review in June 2005, CRWRC adopted the technical strategy of Community/Household Integrated Management of Childhood Illnesses (C-IMCI). One of the technical interventions focused on building sustainability into the Child Survival Project using the Child Survival Sustainability Assessment (CSSA) and exploring the role of community values and beliefs in the assessment of child survival sustainability. The other technical intervention was a behavior change communication strategy known as Theater for Development that has seen much success in the Bangladeshi context. A list of the major activities accomplished concerning the technical interventions and the status of each activity appears in Table 4.

Community/Household Integrated Management of Childhood Illnesses

C-IMCI is defined as "one of the three components of IMCI that aims to initiate, reinforce and sustain healthy practices of the families and communities that are important for survival, growth and development of the children (IMCI, 2004)." C-IMCI is a multi-sector platform that includes three elements:

1) Improving partnerships between health facilities (and services) and the communities they serve;
2) Increasing appropriate and accessible care and information from community-based providers; and
3) Integrated promotion of key family practices critical for child health and nutrition.

CRWRC addressed the three elements of C-IMCI in the intervention activities as well as indirectly addressed the first two components of the national IMCI strategy in collaboration with the Government of Bangladesh (GOB) and other Private Voluntary Organizations (PVOs). This year CRWRC became a member of the National IMCI Working Group in Bangladesh and attended the IMCI Clinical Management Training for Doctors. The Project Officer is scheduled to attend the C-IMCI Training of Trainers course in November 2005.

The overall goal of CRWRC's Child Survival Project is aligned with the overall objective of the C-IMCI strategy in Bangladesh: "To develop the capacities of families and communities to improve caring and care-seeking practices for children's health, nutrition, growth and development (IMCI, 2004)." The majority of CRWRC's intervention activities are focused on the integrated promotion of key family practices critical for child health and nutrition, as adopted by WHO and UNICEF (CSTS, 2001). CRWRC used these key family practices as a guideline to develop the intervention activities. Although

there are no national training modules for these key family practices, CRWRC developed all training curricula for TBAs and CHVs consistent with government guidelines and C-IMCI principles.

The first element of C-IMCI is addressed through CRWRC's referral strategy developed from the HFA and implemented by CHVs and TTBAs in all three target areas. Through the HFA, collaborative relationships have been initiated with government health facilities, NGO providers and private clinics. Based on the results of the HFA, a referral system was developed to improve relationships between health facilities and the community (see Annex 3 for a sample Referral Card). The second element of C-IMCI is addressed through the increase in appropriate and accessible care through TTBAs as described above. The third element of C-IMCI is addressed through the promotion of key family practices in the primary groups by the CHVs (also described above).

Child Survival Sustainability Assessment

CRWRC began using the CSSA framework in February 2005 as part of a technical assistance grant awarded by USAID in collaboration with CSTS+. The CSSA framework was introduced to CRWRC partner staff in the first year of the CSP during the development of the detailed implementation plan. Following an introduction to the CSSA framework and the six components, each partner developed a vision statement, a goal for each component, and elements/indicators to measure each component.

In June 2005, the three partners revisited the CSSA framework. They discussed which indicators would be most appropriate for each component and which evaluation tool would provide the best measurement for each indicator. Although the validity of all the indicators selected was not ideal, the indicators provide a useful snapshot of each partner's progress on the road to sustainable health. Annex 4 provides the baseline sustainability dashboard for all three partners along with the final list of indicators for each component. CRWRC continues to work with each partner organization to select the most appropriate indicators for each of the six components. Through focusing on these six components, CRWRC hopes that the positive health outcomes achieved by the CSP will be sustainable within each community.

Also part of the technical assistance grant from USAID and CSTS+, CRWRC was asked to explore the role of a community's core values and beliefs in child survival sustainability. All of the representatives from the three partner organizations that attended training in CSSA methodology also participated in a 2-day workshop on the role of values in sustainable health. A total of 34 participants creatively explored the values that are most important to the communities in which they work and the values that are most important to child survival sustainability. The latter part of the workshop was spent designing focus group discussion (FGD) questions that could assess the understanding of values in the communities as well as the presence or absence of specific values important to child survival sustainability.

During June 2005 CRWRC partners conducted FGDs in their working areas. The focus groups were composed of eight to ten people separated by gender. There was a

mixture of race and religion as well as socioeconomic status; however, more poor people were included. A total of 561 primary group members and their husbands were interviewed in the three target areas. The FGD topics included the role of values in health as well as the importance of equality, integrity, knowledge, justice and responsibility to health. An example of the questions used for the FGDs is described in Annex 5. From the FGDs, CRWRC partners found that the values of justice and equality were distorted in certain communities. This has led to health care discrimination based on gender, race, and socioeconomic status. If positive values are distorted or a community embraces values that prevent positive change, then positive health outcomes will be difficult, if not impossible, to sustain. By assessing values and as part of the CSSA, CRWRC hopes to improve the likelihood of sustainability by celebrating values that promote sustainable health and challenging values that prevent sustainable health.

Lastly, in August 2005, CRWRC hosted the *Child Survival Sustainability Workshop: Planning for Assessment and Exploring the Role of Values* which included participants from several PVOs, NGOs and health care providers in Bangladesh as well as the USAID mission in Bangladesh. For a list of participants, see Annex 6. The objectives of this workshop were to further the understanding of the CSSA framework among the PVO and NGO community in Bangladesh; share lessons learned from local and regional partners who have applied the CSSA framework; and explore the role of values and transformational development principles in planning for and assessing sustainability.

Theater for Development

Drama is widely appreciated and enjoyed in Bangladeshi culture. Use of this medium should also help increase the community's capacity to provide preventive and promotional health services. Rather than remain dependent on an outside drama team to deliver these health messages, Bengal Creative Media (BCM) conducted the "Theatre for Development" training for community members. In the Dhaka, Netrokona and Panchagor project areas, a local drama team was trained from the community and performed a drama incorporating key family practices for maternal and child health. There were over 1,500 community members in attendance in all three working areas. All three projects areas will continue to perform dramas about key family practices throughout the life of the project. To date, 60 community members have been trained in Theatre for Development (TFD).

Table 4: Major Accomplishments in Technical Interventions

Technical Interventions	Key Activities	Status of Activities	Comments
Community/House hold Management of Childhood Illness (C-IMCI)	▪ Conduct HFA survey ▪ Prepare referral strategies ▪ Train TBAs and CHVs ▪ Form primary groups and adolescent groups	Complete Complete Complete Complete	See Table 2 for a complete list of all groups formed and beneficiaries reached year-to-date
Child Survival Sustainability Assessment	▪ Train partner staff in the CSSA and the role of values in assessing child survival	Complete	See Annex 4 for a list of indicators and dashboards for each project

(CSSA)	sustainability (3 workshops) ▪ Select appropriate indicators to assess each component of the CSSA ▪ Create sustainability dashboards for each project ▪ Conduct focus groups on the role of values in sustainable health ▪ Train local stakeholders in the CSSA and the role of values in assessing child survival sustainability ▪ Prepare paper on the role of values in assessing child survival sustainability	 Complete Complete Complete Complete In progress	Final version due to CSTS+ on October 31, 2005
Theater for Development	▪ Train primary group members in community dramas ▪ Perform community dramas to communicate health messages	Complete Complete	60 men and women (20 in each project) have been trained to carry out Theater for Development. In addition to the initial training, the new theatre groups each performed one drama in their areas.

B. Constraints to Achieving Goals and Objectives

Although much of the first year was spent in training and orienting staff as well as conducting qualitative and quantitative baseline surveys, most of the targets set for year one were accomplished. The number of children under-five was slightly below target for Sathi. However, we anticipate that as Sathi works more with the broader community, more children will be added to this program. We anticipate that the target number for the end of the second year will be achieved.

C. Technical Assistance Required

At the end of the first year, CRWRC has determined two areas in which technical assistance is needed. The first area involves CRWRC's formative research on community values related to child survival sustainability. From this research it became evident that if positive values are distorted or a community embraces values that prevent positive change, then positive health outcomes will be difficult, if not impossible, to sustain. Therefore, CRWRC hopes to obtain further technical assistance from USAID and CSTS+ to discover the most effective, community-owned method for assessing values and measuring change in values related to sustainable health. This research would be integrated with the ongoing assessment of sustainability using the CSSA framework.

CRWRC also requires technical assistance in procuring zinc for the proposed operations research on the *Impact of Zinc and/or Anthelmintics Supplementation in Addition to Health Promotion in Malnourished Bangladeshi Children.* This research was

to begin during the first year of the Child Survival Project, but was placed on hold due to a delay in zinc procurement from Nutriset. CRWRC hopes to continue the zinc research once a waiver to procure zinc from Nutriset becomes available. Please see Annex 7 for details regarding the delay in zinc procurement from USAID.

D. Program Changes

CRWRC had planned to purchase zinc from Nutriset for distribution to the community by Community Health Volunteers. The community members would not have to purchase the zinc during the course of the project. Zinc would be provided free of charge for those community members who needed it. However, CRWRC determined that the use of zinc to treat diarrheal disease and ARI in the community would be more sustainable if the zinc was obtained by the community from local providers. Therefore, zinc supplements will no longer be purchased for treatment of diarrhea and ARI in CRWRC program areas as described in the DIP. Instead, CRWRC will incorporate health messages about zinc in its C-IMCI strategy as well as hold zinc awareness meetings for village doctors, pharmacists and private practitioners. CRWRC will continue to advocate for the use of zinc to treat diarrheal disease and ARI, as well as promote providers who can deliver high quality zinc supplements. The money designated for zinc supplements will now be redistributed into zinc operations research, zinc training/meetings, travel (domestic and international) and health education strategies with Global Learning Partners. The new budget and budget narrative is provided in Annex 8.

Also, as mentioned in the previous section, the operations research using zinc will be postponed until further notice from USAID.

E. Sustainability Plan

CRWRC recognizes the importance of building sustainability into its interventions. Believing that community organizations should not remain dependent on either the PVO or the local NGO, CRWRC's Child Survival Project focuses on building the capacity of the communities in order to sustain positive health outcomes. One way in which CRWRC ensures the long-term success of their CSP strategic objectives is by using the Thana Federation structure. As described in Section A, primary groups are encouraged to each send one representative to a Central Committee. The Central Committee has increased savings and loan ability, in comparison to the primary groups. They also represent primary groups and are a mechanism for supervision and education. Likewise, Central Committees each send one representative to a regional group called a People's Institution. Once a People's Institution is able to achieve independent status, it is recognized by the Government as a registered NGO and is then referred to as a Thana Federation (see Annex 2 for Thana Federation structure).CRWRC and its partners consult with all these groups to build community and organizational capacity and viability. Education in effective health message presentation has the potential to

impact all the Central Committees and primary groups represented, and is more sustainable than the foreign PVO.

Improved access to health services will be sustained by the Thana Federations. Through capacity building activities, the Federations will continue to network for health services in their communities. As part of the Thana Federation health committee, the CHVs will continue to work for access of services needed. The Thana Federation in Panchagor received its Government registration in December 2004. This registration will help them in networking and procuring resources. The People's Institutions in Sathi have begun the registration process. The Thana Federations in Netrokona are currently being formed. All three Federations have started their emergency medical funds which will be used for emergency transportation and other health related items including deworming medicine and iron tablets (in areas where not available from the Government).

As mentioned earlier, CRWRC is also implementing the Child Survival Sustainability Assessment (CSSA) framework in all three program areas in order to monitor the sustainability of health outcomes. All three areas have collected and analyzed data on the six components of the CSSA framework (Annex 4). This data will continue to be assessed on a biannual basis.

F. Responses to DIP Recommendations

The following items were requested by USAID following the DIP workshop in June 2005 (all items have been included into the revised DIP that was submitted to USAID on July 29, 2005):

1) Clarify that iron supplementation will be given by other local providers in the area.

   Iron tablet supplies are available in target areas through the MOH. In Panchagor, the GOB has agreed to allow CSP CHVs to deliver iron supplements as well as vitamin A to pregnant women. It is CRWRC's hope that all three program areas will reach an agreement with the GOB for CHVs to deliver these supplements.

2) Revisit the TBAs and their training (i.e., clarifying what drugs/products they will be distributing, potentially using HBLSS for training, referral strategies).

   The Government of Bangladesh TBA training curriculum was initially, with some modification, followed for the CSP TBA training. This is normally a 12 day knowledge based training course for only two hours per day. However, our three subcontract agencies (Radda Barnen, Joyramkura and LAMB) have modified this to be a 13 day (full-day) residential program (except for Dhaka, which is full-day, non-residential) focused on skills based work including practical demonstrations and hospital/clinic work. LAMB Hospital has submitted their TBA training curriculum to the GOB and is hopeful that it will be used as the national TBA training curriculum. These trainings

are standardized across all three program areas. The training curriculum includes the following lessons:

Sessions	Topics
Lesson: 1	Cause of maternal and neonatal death and its prevention
Lesson: 2	Dietary practice during pregnancy
Lesson: 3	Adequate rest and work load during pregnancy
Lesson: 4	Schedule of TT immunization during pregnancy
Lesson: 5	Birth kit and its use
Lesson: 6	Delivery place and its environment, and hygiene
Lesson: 7	Preparation and Techniques of delivery
Lesson: 8	Newborn care
Lesson: 9	Newborn cord care
Lesson: 10	Identification of high risk pregnancy and complicated delivery, and referral
Lesson: 11	Antenatal checkup
Lesson: 12	Hospital placement

Micro-nutrient distribution is different in different program areas. Government institutions provide micro-nutrients and in some cases the Government allows CRWRC to deliver iron and vitamin A through the CHVs. This already takes place in Panchagor, and we hope the other two areas will follow. The TBAs and CHVs do not distribute any drugs to anyone, but they will network with local clinics and health facilities to provide deworming and other medications for women and children.

3) Clarify the nutrition program per the FANTA reviewer comments.

The Positive Deviance (PD)/Hearth model will be used to address the critical intervention areas identified by the communities. CRWRC will train partner staff, and then community health volunteers (the health technical team members and CHVs) in December 2005. Following the training, CRWRC will proceed through the 9 steps of the PD/Hearth process in all three program areas. Through identifying the positive deviants we hope to identify the key positive behaviors and then influence the caregivers and their care of young children in feeding practices. Hearth Sessions will follow the *Resource Guide for Sustainably Rehabilitating Malnourished Children* (CORE, 2003). Staff will work with each health volunteer/CHV in setting up the Hearth protocol for their community. CRWRC anticipates that the 12 day Hearth sessions will be conducted 2-3 times in the year. As caregivers and their community members learn about supplemental and energy rich foods, the Thana Federations will work with them to ensure that this is sustainable and that nutritional practices in the communities will improve. In August and September 2005 the PD/Hearth training programs will be developed following the Dialogue Education (Vella, 2002) approach. We will seek support from Global Learning Partners to ensure that the PD/Hearth trainings are learner centered. The Hearth approach will be an alternative to institutional feeding centers which are also unavailable in the local communities. Through this approach, the Thana Federations will set up sustainable alternatives in ensuring that malnourished children get necessary nutrition.

Also, when severely malnourished children are identified through growth monitoring and/or other weight assessments, CHVs and TTBAs will establish links with local health facilities for referral of these children for medical care.

4) Revise M&E plan according to standard indicators, and also discuss if the number of indicators can be reduced and/or streamlined for the three project sites.

   See Annex 9 for the *Project-Wide Monitoring and Evaluation Plan*.

5) Adjust baseline reporting per M&E recommendations and include plans for revised sampling at mid-term (optional) and final.

   The sampling methodology has been revised according to USAID recommendations. The following changes will be made to the baseline and for the mid-term and final survey:
   - In order to address the four Rapid CATCH indicators with wide confidence intervals at baseline, the estimates for these Rapid CATCH indicators were combined for each district using weights (based on the population of each district) in order to obtain project wide estimates.
   - For the mid-term and final survey, the Rapid CATCH indicator on increased fluid and feeding during an illness will be changed to include any illness not just during diarrhea.
   - The target for the Rapid CATCH indicator for complementary feeding is within the confidence intervals for district baseline estimates. The target has been adjusted and can be seen in Annex 9.
   - A table for project objectives that includes numerator, denominator, percent and confidence interval as well as EOP targets has been added to Annex 9 entitled *Project-Wide Monitoring and Evaluation Plan*. All targets within the baseline confidence intervals have been adjusted.
   - The sample size has been increased for each district intervention area to 300 in order to avoid wide confidence intervals for some of the indicators and to obtain meaningful district level estimates.

6) Discuss whether or not the number of intervention areas proposed is appropriate.

   The current intervention mix will be followed and is appropriate:

Partner NGO	EPI	BF	NUT	Micro-nutrients	Vit. A	CDD	PCM	Malaria	MNC	Child Spacing	FP	HIV/ AIDS	TB	Other Diseases
Original Proposal	10	5	25	20	5	10	10		15					
Pari	10	5	25	15	5	10	10		15			5		
Sathi	10	5	25	15	5	10	10		15			5		
Supoth	10	5	25	15	5	10	10		15			5		

= Changes in proposed interventions

7) If there are any changes to the budget, please submit a revised budget and budget narrative.

   See Annex 8 for the revised budget and budget narrative.

8) C-IMCI strategy:
   a. Describe how nutrition and immunization elements will be incorporated into the C-IMCI strategy in addition to the CDD and PCM elements as previously proposed; revise objectives accordingly.

      The strategic objectives have been revised as follows:
      - Improve maternal and neonatal care.
      - Prevent and properly treat diarrheal disease.
      - Detect ARI and make appropriate referrals.
      - Improve child nutrition.
      - Reduce mortality and morbidity from vaccine preventable diseases.
      - Increase awareness about HIV/AIDS.

      These six strategic objectives have been incorporated into the three components of the C-IMCI strategy. All of the intervention activities are focused on the integrated promotion of key family practices critical for child health and nutrition, as adopted by WHO and UNICEF. CRWRC used these key family practices as a guideline to develop the intervention activities.

   b. Discuss how the project will address Elements 1 and 2 of the C-IMCI Framework.

      The first element of C-IMCI is addressed through CRWRC's referral strategy developed from the HFA and implemented by CHVs and TTBAs in all three target areas. Through the HFA, collaborative relationships have been initiated with government health facilities, NGO providers and private clinics. Based on the results of the HFA, a referral system was developed to improve relationships between health facilities and the community (see Annex 3 for a sample Referral Card). The second element of C-IMCI is addressed through the increase in appropriate and accessible care through TTBAs as described in Section A. The third element of C-IMCI is addressed through the promotion of key family practices in the primary groups by the CHVs (also described in Section A).

G. Indicators Reporting Table for Programs Receiving FP Support

This program does not receive any Family Planning support from USAID.

H. Management System

Financial Management System

The NGO Affairs Bureau in Bangladesh approved the budget for the Child Survival Project of CRWRC. The project has a full time Finance Officer who is based at the CRWRC office in Dhaka, Bangladesh. A quarterly reporting template was set up by the CRWRC International Finance Coordinator in the U.S., which is completed by CRWRC staff in Bangladesh each quarter. Each of the three partner organizations maintains separate bank accounts for the CSP. CRWRC receives payments for the CSP from its U.S. office. It then pays grants to the partners and sub-contracting organizations per the agreement with USAID and according to the regulations of the GOB. All vouchers and receipts related to the project are kept in the Dhaka office. The Finance Officer conducts quarterly visits to each of the three partner organizations to do an internal audit of the financial activities. The CSP Program Manager is responsible for the overall financial system and reviews and approves all financial reports. As part of the end of the first fiscal year, an external financial audit and financial management review will take place from October 26, 2005 and will be conducted by a GOB approved firm, Azad Zamir and Company. CRWRC will submit the first year financial audit report to USAID by December 2005.

Human Resources

As there are three different projects (Sathi, Supoth and Pari) working under the CRWRC CSP, field staff (health animators) for the Child Survival Project were hired by the specific projects, with input from the CSP Program Manager. The three coordinators were hired by each project, with interviews conducted by the project directors and the CSP Program Manager. Job Descriptions for these positions were prepared jointly by the three projects with input and final approval from the CSP Program Manager. There are currently 16 CSP health animators: four in Sathi, six in Supoth and six in Pari. Each organization also has a CSP Health Coordinator. All positions were filled by January 2005. However, each partner organization lost one health animator in the first year. These three staff were nurses who were assigned Government jobs and had to leave the projects. All vacant positions have since been filled. All of the health animators hired have previous experience working in health related programs. The three Health Coordinators all have field experience as well as managerial experience.

All CSP staff received an initial two-week orientation to the specific project in which they were working. They also received a one-week orientation on the Child Survival Project. In addition to this, they had extensive training in specific health related topics including baseline survey conduction, nutrition surveillance, values and health, CSSA, and supervision of CHVs and TBAs.

All annual performance assessments of each CSP staff have been completed. These are on file in each project office as well as in the CRWRC office. Biannual reviews take place in March of each year.

Communication System and Team Development

The CSP Manager meets with the three Health Coordinators, the Monitoring and Evaluation Consultant and the Program Officer on a monthly basis. Monthly reports are presented by each project at this time and variances are reviewed. Mini-trainings on management and specific CSP related topics are included in these two-day meetings. Also, each work plan is reviewed and finalized for the coming month. The CSP Program Manager has monthly communication with the Project Directors of each of the three projects regarding CSP activities. CRWRC CSP staff visit each project on a quarterly basis. Each of the three projects also has its own internal management system. The Health Coordinators of each of the projects is a member of the project management team and reports on CSP activities. CRWRC CSP staff receive copies of the minutes from the project management team meetings. The Health Coordinators also meet with the Field Animators in their projects on a monthly basis. These meetings include activity updates, variance reports, planning and mini-workshops.

Local Partner Relationships

The Learning Circle was formed in 1994 with 4 organizations. It has now expanded to 16 member organizations, with 6 more organizations on a waiting list. CRWRC considers the Learning Circle a valuable part of its consultancy to its partners and to other integrated community development NGOs. Much peer learning takes place with the organizations learning about each other's organizations and giving valuable feedback. The meetings also include mini workshops on various topics, guest speakers from various forums and dissemination of development information.

The three CSP organizations (Sathi, Pari and Supoth) have all been members of the Learning Circle since its inception. These three organizations are long standing partners of CRWRC. Two of the organizations (Pari and Supoth) have become national NGOs with their own registration. Sathi is still a direct project of CRWRC according to the Government Proforma, but it functions like all other partners operating under two year renewable partnership agreements. CRWRC maintains a good relationship with each of the three partners and, as part of the Learning Circle, CRWRC conducts regular surveys regarding the quality of its services to the partners and feedback as to how this can be improved.

PVO Coordination/Collaboration in Country

CRWRC is registered with the NGO Bureau of Bangladesh and has received approval from the government for the Child Survival Project. Each of the three partner organizations are also registered with the NGO Bureau. CRWRC and its partners are also members of various forums in Bangladesh including the PRA Forum, the Self Help Forum, the National Aids Programs Forum, the Arsenic Forum and the Voluntary Health Association of Bangladesh. In addition to this, CRWRC is a member of the White Ribbon Alliance of Bangladesh, the National C-IMCI Working Group, and MotherNewborNet, which is supported by USAID and coordinated through the International Center for Diarrheal Disease Research in Bangladesh (ICDDR,B).

As described above, CRWRC also hosts a quarterly Learning Circle forum that consists of sixteen local NGOs, all of whom have health programs. The Learning Circle includes training on various health-related topics and lessons learned from the Child Survival Project.

CRWRC also had several informal meetings with Concern Worldwide, Inc. (CWI) in Bangladesh regarding child survival activities. CRWRC and Concern Worldwide have agreed to meet on a quarterly basis to discuss their Child Survival Projects. CWI Bangladesh also invited the CRWRC Project Manager and Monitoring and Evaluation Consultant to participate in their upcoming BEHAVE training later this year. In addition to collaborating with CWI, CRWRC invited a wide range of PVOs in Bangladesh participate in the Child Survival Sustainability Workshop in August 2005. For a list of participating PVOs, see Annex 6.

Other Relevant Management Systems
CRWRC maintains regular contact with the subcontracting organizations, including BCM, LAMB, Joyramkura and Radda Barnen. All partnership agreements with these institutions are finalized and cover the five-year CSP period. The CRWRC CSP Program Manager also meets with each of these institutions biannually to review progress and address any concerns.

As noted, CRWRC is involved with the three partner organizations in other integrated community development activities as well as the CSP. These activities are also reported on a quarterly basis.

Organizational Capacity Assessment
Over the past decade, CRWRC and its partner organizations developed an extensive organizational capacity indicator (OCI) system that is measured biannually by each project board, staff and stakeholders. Each community also uses a community capacity indicator (CCI) system to measure their progress. In this past year, the three partner organizations incorporated the OCI and CCI systems into the CSSA. Baselines on the dashboard have been set (see Annex 4) and the next measurement will take place in January 2006.

I. Mission Collaboration

CRWRC Bangladesh has maintained regular contact with the local mission throughout the first year of the grant. CRWRC's primary contacts at the USAID mission are Dr. Sukumar Sarker and Ms. Carrie Rasmussen of the Health and Population Division. In addition, CRWRC staff briefed Ms. Lynn Gorton, the new Chief of the Population and Health Division of USAID, Dhaka, on the CRWRC Child Survival Project in August 2005.

During the writing of the DIP, the CRWRC CSP Program Manager met with officials at the USAID mission four times regarding the DIP and the mission's recommendations

regarding appropriate activities. The mission gave valuable input into the DIP on items relating to mission priorities and also collaboration with the Government. The mission recommended CRWRC's inclusion into the C-IMCI development committee that is managed by the Ministry of Health. CRWRC now regularly participates in this group that is working to develop the C-IMCI strategy in Bangladesh.

Dr. Sarker and Ms. Rasmussen participated in the USAID-funded Child Survival Sustainability Workshop facilitated by CRWRC in August 2005. Ms. Rasmussen is particularly interested in CRWRC's work on values related to sustainable health and has reviewed the draft paper submitted to CSTS+.

Dr. Sarker and Ms. Rasmussen have a plan to visit the Dhaka CSP fields in October, and will visit Netrokona in November. The mission and CRWRC are in frequent communication with each other, either through meetings or phone contacts. The USAID mission keeps CRWRC informed of mission activities and workshops and seeks our input on various items as needed. CRWRC has a very positive relationship with USAID, which has helped to improve the quality of the Child Survival Project. We foresee that this relationship will continue to strengthen throughout the next four years of the grant.

J. Timeline for FY 2006

1) CHV, TBA and TFD Training Program for Year Two

Particulars	Partner Organization	Number	Time (Month and Year)	Conducted by
TBA Training	SATHI 1st Batch 2nd Batch Total	 16 16 32	 July 2006 August 2006	Radda Barnen
	PARI	25	June 2006	Joyramkura
	SUPOTH 1st Batch 2nd Batch 3rd Batch Total	 8 8 9 25	 Mar 20-Apr 6, 2006 April 1-20, 2006 May 13-30, 2006	LAMB
CHV Training	SATHI	48	April-June 2006	Radda Barnen
	PARI	60	March-July 2006	Joyramkura
	SUPOTH	30	February 2006	LAMB
TBA Refresher Course	SATHI	32	June 2006	Radda Barnen
	PARI	25		Joyramkura
	SUPOTH	25		LAMB
Training in Theatre for Development	SATHI	20	March to May 2006	BCM
	PARI	20		
	SUPOTH	20		

2) Timeline of Other Major Activities

Activities	Participants	Location	Date
PD/Hearth workshop (followed by the PD/Hearth program in all communities on a regular basis).	19 Health Coordinators and Health Animators from the 3 projects.	CRWRC offices, Dhaka	December 6-8, 2005
CHV and TBA supervision workshop	19 Health Coordinators and Health Animators from the 3 projects.	Conducted by LAMB at LAMB Hospital	December 11-18, 2005
BEHAVE Workshop (conducted by CWI Bangladesh)	CRWRC CSP Monitoring and Evaluation Consultant and CSP Manager	CWI Bangladesh Offices	December 2005 or January 2006 (to be decided by CWI)
Nutrition Surveillance	Communities under CSP; Survey conducted by CSP staff in each project	In Panchagor, Netrokona and Dhaka	January and July, 2006
Dashboard and OCI/CCI measurement	Staff and community members in the 3 projects.	In Panchagor, Netrokona and Dhaka	January and June, 2006
Workshops on Key Health Messages for People of Influence	Village Doctors, Community Leaders, etc.	Netrokona, Panchagor and Dhaka	February and August, 2006
BEHAVE Workshop (conducted by CRWRC Technical Back Stop)	CSP Coordinators and Health Animators	CRWRC offices, Dhaka	March 2006
Dialogue Education Basic Workshop	CSP Coordinators and trainers from LAMB, Radda Barnen and Joyramkura	CRWRC offices, Dhaka	April 2005
Dialogue Education Advanced Workshop	CSP Coordinators and trainers from LAMB, Radda Barnen and Joyramkura	CRWRC offices, Dhaka	August 2006
Zinc Research	For Kamalkanda and Durgapur communities per DIP	Netrokona	Postponed until USAID waiver with Nutriset is finalized

In addition to the aforementioned major activities, CRWRC will continue to implement the following ongoing activities in year two:

- Primary group formation and development
- Growth monitoring
- Health promotion classes
- Development of health technical teams
- Community and organizational capacity development
- Learning Circle dissemination of learning and mini workshops
- PD/Hearth sessions in the community
- Behavior change activities
- Emergency fund development
- TTBA and CHV development and monitoring

K. Key Areas of Success

Due to the early stage of the Child Survival Project, CRWRC does not have any key areas of success to report. However, CRWRC has a number of promising practices which may become key areas of success in the years to come. A list of the promising practices can be found in Section L.1 *Contribution to Scale/Scale-Up* and L.3 *Widespread Development or Adoption of Innovative Approaches.*

L. Other Relevant Topics

1. Contribution to Scale/Scaling-Up

CRWRC plans to scale-up successful interventions using the Thana Federation structure described in Section A and depicted in Annex 1. Within this structure, the primary and intermediate (CCCs) groups are the catalysts for health in the broader community. The groups represent the poor, who are being empowered to assist the community in better health practices. Each partner organization concentrates on developing the capacity of the primary and intermediate groups, and these groups bring new knowledge to the rest of the community. This structure promises to have a significant impact on a multitude of health-related factors including pre-natal, natal, and post-natal care; identifying childhood illnesses; appropriate treatment for diarrhea and ARI; nutrition; vaccinations; and HIV/AIDS education.

Also, Community Health Volunteers (CHVs) provide a sustainable way to continue health education throughout the community. These volunteers are part of the health technical teams that are formed in each Thana Federation from certain members of the primary groups. The incentive to continue volunteering is provided by the Thana Federations and the health technical teams in the form of continued learning through trainings and workshops. The CHVs will not only provide health education for the members of the primary groups, but they will also provide health education for the broader community.

2. Civil Society Development

Seven Thana Federations are now in place (1 in Panchagor, 2 in Netrokona and 4 in Dhaka). Each of these Federations has established health technical teams. These teams are volunteers and consist of group members who have an interest in developing better health in their communities. The Federations and technical teams then network with the local health complexes as well as health officials at a district level. This networking helps ensure the legitimacy of the Federations in the district as well as provides greater reach for the health technical teams in providing sustainable resources. Leadership in the Federations and the health technical teams rotate on a biannual basis, through elections conducted by the Federations.

Also, LAMB Hospital has developed a skills and knowledge based TBA curriculum that has been used with the CWI CSP and is now being used with the CRWRC CSP. LAMB is presenting this curriculum to the GOB on November 27, 2005 in the hope of receiving approval for this as the national curriculum for training TBAs. CWI has been involved in advocating for this as part of their Phase One Child Survival Program. Once this is approved by the Government as the national curriculum, CRWRC will ensure that Radda Barnen and Joyramkura also follow this syllabus.

3. Widespread Development or Adoption of Innovative Approaches

CRWRC developed Organizational Capacity Indicators (OCIs) in order to assess the capacity and viability of their partner organizations. Along with their partners, CRWRC has also created Community Capacity Indicators (CCIs) to assess the capacity and sustainability of communities. These two assessment tools have been incorporated into the Child Survival Sustainability Assessment (CSSA) framework for measuring the sustainability of CRWRC's five year child survival program. These assessment tools have been used by all three partners to assess the likelihood of sustainability at the baseline (Annex 4). The CSSA will continue to be used by all three partners biannually to monitor the child survival sustainability. The CSSA was also shared with the greater PVO and healthcare community in Bangladesh.

In conjunction with the CSSA, CRWRC also explored the role of community values in assessing child survival sustainability. CRWRC's work with values will hopefully lead to the long-term success of their child survival interventions. The incorporation of community values into the CSSA was widely accepted by the greater PVO and healthcare community in Bangladesh. CRWRC submitted an abstract about the role of community values on child survival sustainability to the 33rd Annual International Conference on Global Health in June 2006 (Annex 11).

According to CRWRC's baseline survey and the first nutritional surveillance survey, there is little use of zinc to treat diarrhea in the community. CRWRC will continue to train CHVs, village doctors, pharmacists, and private practitioners on the importance of using zinc to treat diarrhea and ARI.

CRWRC will also continue to use Theater for Development to reach an audience outside of the primary groups with general health messages as described in Section A. This is a sustainable tool for health education at the community level because the community members are trained to write and perform the health dramas.

Lastly, CRWRC hold a Learning Circle meeting every quarter to share best practices and innovative approaches to community development. There are 16 local NGOs in Bangladesh and India that attend these Learning Circles. Since the beginning of the CSP seven local NGOs plan to use the OCI/CCI system and the CSSA to measure the sustainability of their projects next year. Also, two of the NGOs have started training TBAs at Joyramkura, one of the training hospitals used by CRWRC's CSP.

CRWRC hopes that these NGOs will continue to pursue promising practices from the CSP.

4. Equity

Prior to forming primary groups, all three projects conducted extensive PRA/PLA surveys to determine, with the community, members that are suitable for the groups. Each of the partners set criteria that identifies the poorest of the poor. The projects select those who are landless (owning less than ten decimals of land) or those that are marginal farmers (low sufficiency/land ownership requiring most food to be purchased and not grown). Women and children are a priority in the programs and the programs also include widows and the disabled.

5. Visibility and Recognition of the Project and PVO Grantee

The following two abstracts have been submitted to appear at the conferences noted below:

Sarkar NR, TenBroek NL, Daring K, and Story WT. Comparison of Health and Nutritional Status between Tribal and Bengali Children Aged 0-23 Months in Rural Bangladesh. Submitted to the 8th Commonwealth Congress on Diarrhea and Malnutrition in Dhaka, Bangladesh. February 2006. (See Annex 10 for Abstract)

Story WT, TenBroek NL and Daring K. The Role of Community Values in Assessing Child Survival Sustainability. Submitted to the 33rd Annual International Conference on Global Health in Washington DC. May 2006. (See Annex 11 for Abstract)

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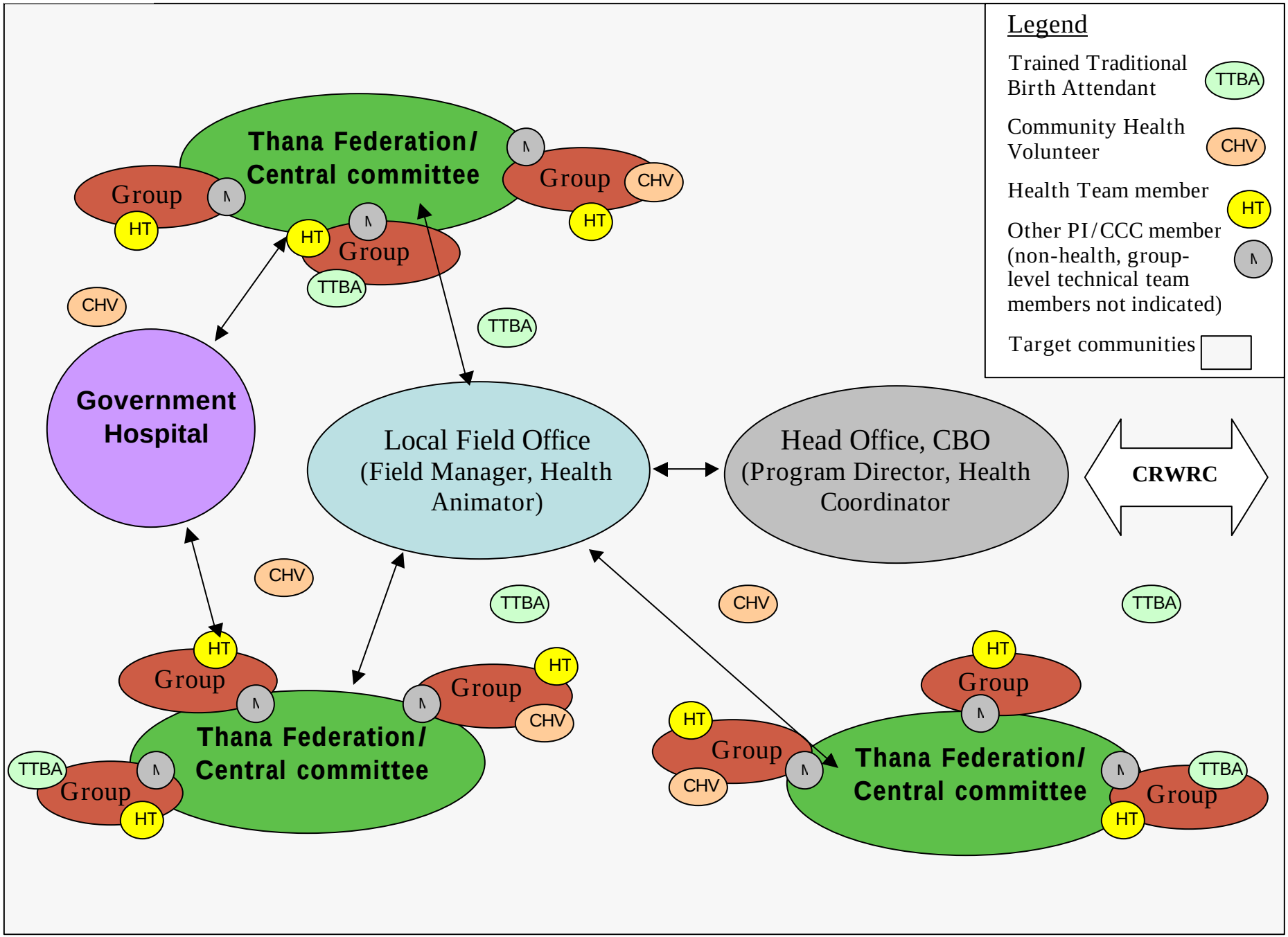
Annex 1


Legend
Trained Traditional Birth Attendant
TTBA
Community Health Volunteer
CHV
Health Team member
HT
Other PI/CCC member (non-health, group-level technical team members not indicated)
Target communities
Thana Federation/ Central committee
Group
HT
CHV
TTBA
Government Hospital
Local Field Office (Field Manager, Health Animator)
Head Office, CBO (Program Director, Health Coordinator
CRWRC

Annex 2

Monitoring and Evaluation Plan from Nutritional Surveillance Data in September 2005.

BOLD = KPC Rapid CATCH Indicators

Intervention areas	***Indicators***	***Panchagar***	***Netrokona***	***Dhaka***
Strategic Objective I. Improve Maternal and Neonatal Care				
Delivery by Skilled Health Personnel (including TTBAs)[1]	Percentage of children aged 0-23 months whose births were attended by skilled health personnel	Numerator: Denominator: Percentage: Baseline %:18	Numerator: Denominator: Percentage: Baseline %: 21	Numerator: Denominator: Percentage: Baseline %: 35
Prenatal Care Coverage	Percentage of mothers who had at least one prenatal visit prior to the birth of her youngest child less than 24 months of age	Numerator: 254 Denominator: 296 Percentage: 86 Baseline %: 60	Numerator: 126 Denominator: 300 Percentage: 42 Baseline %: 49	Numerator: 249 Denominator: 292 Percentage: 85 Baseline %: 85
Tetanus Toxoid (TT)	**Percentage of mothers who received at least two tetanus toxoid injections before the birth of the youngest child less than 24 months of age**	**Numerator: 189** **Denominator: 300** **Percentage: 63** **Baseline %: 80**	**Numerator: 183** **Denominator: 300** **Percentage: 61** **Baseline %: 62**	**Numerator: 142** **Denominator: 300** **Percentage: 47** **Baseline %: 59**
Knowledge on Maternal Danger Signs/Symptoms[2]	Percent of mothers of children age 0-23 months able to report at least two known maternal danger signs/symptoms during the prenatal, natal and postnatal period	Numerator: Denominator: Percentage: Baseline %: 33	Numerator: Denominator: Percentage: Baseline %: 31	Numerator: Denominator: Percentage: Baseline %: 37

[1, 2]Data not collected in the Nutrition Surveillance

Intervention areas	*Indicators*	*Panchagar*	*Netrokona*	*Dhaka*
Strategic Objective II. Prevent and Properly Treat Diarrheal Disease				
ORT Use During Diarrheal Episode	Percentage of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids (RHF)	Numerator: 12 Denominator: 23 Percentage: 52 Baseline %: 64	Numerator: 68 Denominator: 84 Percentage: 81 Baseline %: 56	Numerator: 30 Denominator: 51 Percentage: 59 Baseline %: 55
Increased Fluid and Continued Feeding During a Diarrheal Episode	Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered more fluids AND the same amount or more food during the diarrheal episode	Numerator: 13 Denominator: 23 Percentage: 57 Baseline %: 7	Numerator: 53 Denominator: 84 Percentage: 63 Baseline %: 7	Numerator: 47 Denominator: 51 Percentage: 92 Baseline %: 27
Increased Fluid and Continued Feeding During an illness	**Percent of children aged 0-23 months with an illness in the last two weeks who were offered more fluids AND the same amount or more food**	**Numerator: 70 Denominator: 123 Percentage: 57 Baseline %: NA**	**Numerator: 149 Denominator: 233 Percentage: 64 Baseline %: NA**	**Numerator: 158 Denominator: 168 Percentage: 94 Baseline %: NA**
Zinc Supplementation During Diarrheal Episode	Percentage of children aged 0-23 months with diarrhea in the last two weeks who received recommended oral zinc therapy during the illness	Numerator: 2 Denominator: 23 Percentage: 9 Baseline %: 14	Numerator: 0 Denominator: 84 Percentage: 0 Baseline %: 11	Numerator: 2 Denominator: 51 Percentage: 4 Baseline %: 9
Availability of Soap for Hand Washing	**Percentage of mothers of children age 0-23 months that have soap readily available for hand washing**	**Numerator: 45 Denominator: 300 Percentage: 15 Baseline %: 53**	**Numerator: 106 Denominator: 300 Percentage: 35 Baseline %: 15**	**Numerator: 158 Denominator: 300 Percentage: 80 Baseline %: 37**

Intervention areas	*Indicators*	*Panchagar*	*Netrokona*	*Dhaka*
Strategic Objective III. Detect ARI and Make Appropriate Referrals				
ARI Care Seeking	Percentage of children aged 0-23 months with fast or difficult breathing and/or cough in the last two weeks who were taken to a health facility	Numerator: 3 Denominator: 34 Percentage: 9 Baseline %: 29	Numerator: 42 Denominator: 78 Percentage: 54 Baseline %: 8	Numerator: 13 Denominator: 19 Percentage: 72 Baseline %: 63
Maternal Knowledge of Child Danger Signs/ Symptoms	**Percentage of mothers of children age 0-23 months who report at least two of child danger signs/symptoms**	**Numerator: 188 Denominator: 300 Percentage: 63 Baseline %: 70**	**Numerator: 279 Denominator: 300 Percentage: 93 Baseline %: 73**	**Numerator: 200 Denominator: 300 Percentage: 67 Baseline %: 28**

Intervention areas	*Indicators*	*Panchagar*	*Netrokona*	*Dhaka*
Strategic Objective IV. Improve Child Nutrition				
Underweight	**Percentage of children aged 0-23 months who are more than 2 standard deviations (SD) below the median weight-for-age (WA) of the WHO/NCHS reference population**	**Numerator: 110 Denominator: 300 Percentage: 37 Baseline %: 38**	**Numerator: 142 Denominator: 300 Percentage: 47 Baseline %: 41**	**Numerator: 114 Denominator: 300 Percentage: 38 Baseline %: 39**
Exclusive Breastfeeding	**Percentage of children aged 0-5 months who were fed breast milk only in the last 24 hours**	**Numerator: 39 Denominator: 64 Percentage: 61 Baseline %: 88**	**Numerator: 17 Denominator: 51 Percentage: 33 Baseline %: 74**	**Numerator: 44 Denominator: 88 Percentage: 50 Baseline %: 39**
Exclusive Breastfeeding[3]	Percentage of children aged 0-5 months who were fed only breast milk up to 5 months	Numerator: 38 Denominator: 88 Percentage: 43 Baseline %: NA	Numerator: 15 Denominator: 53 Percentage: 28 Baseline %: NA	Numerator: 43 Denominator: 64 Percentage: 67 Baseline %: NA
Appropriate Complementary Feeding Practice	**Percentage of infants aged 6-9 months who received semi-solid or family foods in the last 24 hours**	**Numerator: 52 Denominator: 65 Percentage: 80 Baseline %: 27**	**Numerator: 20 Denominator: 54 Percentage: 37 Baseline %: 14**	**Numerator: 31 Denominator: 52 Percentage: 60 Baseline %: 55**
Vitamin A Coverage	Percentage children aged 6-23 months who received a Vitamin A dose in the past six months	Numerator: 144 Denominator: 236 Percentage: 61 Baseline %: 62	Numerator: 137 Denominator: 245 Percentage: 56 Baseline %: 61	Numerator: 158 Denominator: 211 Percentage: 75 Baseline %: 53

[3]Added indicator as checked by Bangladesh Breastfeeding Foundation and HKI

Intervention areas	*Indicators*	*Panchagar*	*Netrokona*	*Dhaka*
Strategic Objective V. Reduce Morbidity and Mortality from Vaccine Preventable Diseases				
Complete Immunization Coverage[4]	**Percentage of children under 12 months fully immunized with 1 dose each of BCG and measles and 3 doses each of DPT and Polio**	**Numerator:** **Denominator:** **Percentage:** **Baseline %: 57**	**Numerator:** **Denominator:** **Percentage:** **Baseline %: 32**	**Numerator:** **Denominator:** **Percentage:** **Baseline %: 28**
Strategic Objective VI. Increase Awareness of HIV/AIDS				
Maternal Knowledge of HIV Risk Reduction[5]	**Percentage of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving prevention of HIV**	**Numerator:** **Denominator:** **Percentage:** **Baseline %: 12**	**Numerator:** **Denominator:** **Percentage:** **Baseline %: 13**	**Numerator:** **Denominator:** **Percentage:** **Baseline %: 51**

[4,5]Data not collected in the Nutrition Surveillance

Annex 3

REFERRAL SERVICES INFORMATION CARD
Child Health & Survival Program
Sutrapur Area

List of Health Service Centers:

Prenatal Care	Delivery (Normal)	Delivery (Complicated)	Postnatal Care	Child Treatment
❖ Surjer Hasi ❖ Paribarik Shastha Clinic ❖ Salauddin General Hospital ❖ Red Cresecent Hospital	❖ TTBA ❖ Salauddin General Hospital ❖ Red Cresecent Hospital	❖ Salauddin General Hospital ❖ Red Cresecent Hospital	❖ Surjer Hasi ❖ Paribarik Shastha Clinic ❖ Salauddin General Hospital ❖ Red Cresecent Hospital	❖ Surjer Hasi ❖ Paribarik Shastha Clinic ❖ Salauddin General Hospital ❖ Red Cresecent Hospital

স্বাস্থ্য সেবা গ্রহণের জন্য তথ্য কার্ড
মা ও শিশু স্বাস্থ্য কর্মসূচী
সূত্রাপুর এলাকা

স্বাস্থ্য সেবা দানকারী কেন্দ্রের তালিকাঃ

প্রসব পূর্ব যত্ন	প্রসবকালীন যত্ন (স্বাভাবিক)	প্রসবকালীন যত্ন (জটিল)	প্রসবোত্তর যত্ন	শিশুর চিকিৎসা
❖ সূর্যের হাসি ❖ পারিবারিক স্বাস্থ্য ক্লিনিক ❖ সালাউদ্দীন জেনারেল হাসপাতাল ❖ রেডক্রিসেন্ট হাসপাতাল	❖ টিটিবিএ ❖ সালাউদ্দীন জেনারেল হাসপাতাল ❖ রেডক্রিসেন্ট হাসপাতাল	❖ সালাউদ্দীন জেনারেল হাসপাতাল ❖ রেডক্রিসেন্ট হাসপাতাল	❖ সূর্যের হাসি ❖ পারিবারিক স্বাস্থ্য ক্লিনিক ❖ সালাউদ্দীন জেনারেল হাসপাতাল ❖ রেডক্রিসেন্ট হাসপাতাল	❖ সূর্যের হাসি ❖ পারিবারিক স্বাস্থ্য ক্লিনিক ❖ সালাউদ্দীন জেনারেল হাসপাতাল ❖ রেডক্রিসেন্ট হাসপাতাল

Annex 4

PARI Project – Indicators and Dashboard

Component 1 – Health Outcomes

1. Percent of children age 0-23 months who are under-weight
2. Percentage of children age 0-23 months whose delivery was attended by skilled health personnel
3. Percentage of mothers with children 0-23 months who received at least two tetanus toxoid injections before the birth of the youngest child less than 24 months of age
4. Percentage of severe under nourished children under 2 years.
5. Percentage of children under 12 months who are fully immunized against the six vaccine preventable disease before the first birth day
6. Percentage of children aged 0-5 months who were fed breast milk only in the last 24 hours
7. Percent of infant aged 6-9 months who received semi-solid or family foods in the last 24 hours
8. Percent of mothers of children age 0-23 months who mentioned at least two of the responses that relate to safer sex or practices involving prevention of HIV
9. Percentage of mothers of children age 0-23 months that have soap readily available for hand washing
10. Percentage of mothers of children age 0-23 months who report at least two child danger signs/symptoms
11. Percentage of children aged 0-23 months with diarrhea in the last two weeks who were offered more fluids during the illness
12. Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered the same amount or more food during the illness.

Component 2 – Health and Social Services

1. One CHV per 16 households will be trained to work in key area related to maternal child health.
2. One supervisor visits 20 CHVs at least quarterly.
3. Percentage of Vitamin A capsule consumption during postnatal care.
4. Rate of deworming use in children 2-5 years of age every six months.
5. Percentage of pregnant women who received at least 4 prenatal visits.

Component 3 – Organizational Capacity

1. They have constitution/bylaws and policy guideline.
2. There is legal registration of local organization to work in the area
3. There is an agreement to work in a participatory way with other like minded organizations.
4. There is a transparent accounting system.
5. There are representatives from all communities.
6. They hold meeting regularly (once a month)
7. There is participatory planning and implementation.
8. There is an elected and approved management committee.

Component 4 – Organizational Viability

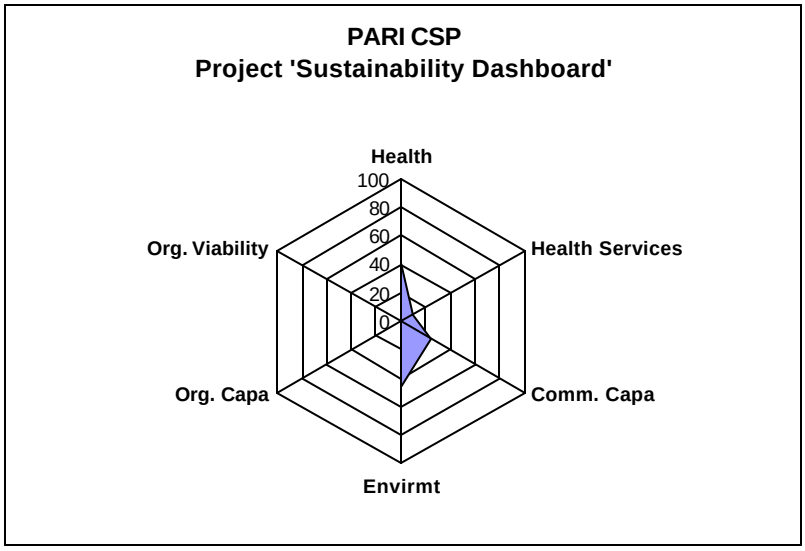
1. Leaders are aware of their responsibilities and financial policy in the organization.
2. The activities of the people's institution are taken on the basis of the demand of the community.
3. Leaders make plans and give training through mutual understanding
4. Transparent responsibility and regular progress are observed.
5. Leaders regularly visit the project activities, progress of works and members of the PI.

Component 5 – Community Competence/Capacity

1. All members accumulate savings regularly.
2. They identify their own problems and solve them by themselves.
3. Five of all members make a plan in a participatory way and everybody knows it.
4. Members select new leaders in democratic way.
5. Groups are respected in the society.

Component 6 – Ecological, Human, Economic, Political and Policy Environment

1. Increase the percentage of household that will have access to sanitary latrine
2. Mothers literacy rate
3. Tubewell water use
4. Tree plantation for keeping ecological balance



SATHI Project – Indicators and Dashboard

Component 1 – Health Outcomes

1. Deliveries attended by TTBAs.
2. Pregnant mothers are immunized at least two dozes of TT.
3. Pregnant mothers know at least two danger signs of pregnancy.
4. Pregnant mothers dietary practices during pregnancy.
5. All eligible children are immunized.
6. Children continue exclusive breast feeding.
7. Children continue breast feeding up to two years.
8. Children receive complementary food from 6 months.
9. Children under 2 years of age received anti-helminthic every 6 months.
10. Children received extra fluid during diarrhea and illness.
11. Children are taking zinc during diarrhea.
12. Children under age 2 are growing according to their age and height.

Component 2 – Health and Social Services

1. The community has trained TBAs and CHVs who provide services to the community on CSP.
2. Pregnant mothers received a check –up during pregnancy at least 4 times.
3. The postpartum and lactating mothers received Vitamin A capsule within 6 weeks after delivery.
4. The pregnant mothers received iron tablet during pregnancy.
5. The People's Institution (PI) health fund is being used for addressing emergency maternal and child illness as per their policy.

Component 3 – Organizational Capacity

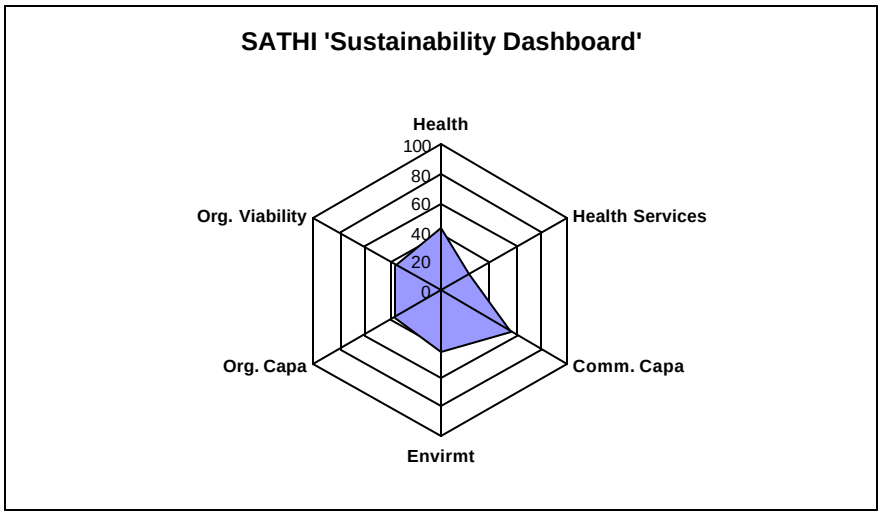
1. Policies are in place which are followed regularly and reviewed as necessary.
2. PI has registration.
3. There are equal opportunities for both male and female members for learning and training.
4. The PI practices equal responsibilities as well as opportunities for both male and female members.
5. PI has visionary and every PI has 5 good leaders.

6. PI has strong fund raising plan as well as capacity.
7. PI has approved and transparent account keeping system and 5 members are capable of maintaining accounts.

Component 4 – Organizational Viability
1. PI executive committee is well aware of the policies and they practice them.
2. PI implements community based program effectively.
3. PI has training program for group members on health.
4. PI executive committee is well known about GO/NGO health services and they have a good relationship with them.
5. There is a clear accountability and regular monitoring system.

Component 5 – Community Competence/Capacity
1. All members of the groups are doing savings regularly of their own accord and managing by themselves.
2. Group is well respected and accepted in the society.
3. They have five skilled members who are implementing the plan following the participatory way.
4. All groups have their own bylaws which they follow.
5. They have skilled leaders and change the leadership body each year through participatory and democratic process.
6. Group members continue the literacy course and encourage others in the community to take the literacy course and practice it regularly.
7. Members can properly write the passbooks as well as understand about the keeping of accurate passbooks and help others in writing.
8. Group plays an active role in GO and NGO bodies through their intermediary group for receiving their services for the community.

Component 6 – Ecological, Human, Economic, Political and Policy Environment
1. Community people have access to safe water.
2. The community people are aware of the marriage law and can state at least 4 issues.
3. The community people are aware of civil rights and they are enjoying.
4. The literacy rate increases in women of reproductive age.
5. Community people have access sanitary latrines.



SUPOTH Project – Indicators and Dashboard

Component 1 – Health Outcomes
Same as PARI

Component 2 – Health and Social Services

1. One Community Health Volunteer for every 37 households will be trained to work in key areas related to maternal-child health.
2. Every 20 health volunteers will have a supervisor who visited and observed their job performance at least quarterly.
3. Percentage of pregnant women given standard doses of iron tablet and V-A at proper intervals.
4. Percentage of postpartum and lactating women given standard doses of iron, folate, and V-A at proper intervals.
5. Percentage of pregnant women given anthelmintic treatment during their second trimester of pregnancy.

Component 3 – Organizational Capacity

1. Policies are in place and assured they are regular.
2. The organization has legal permission to work.
3. Working agreement with other partners and other collaborating organizations are in place.
4. There is demonstrated fund raising /marketing ability.

Component 4 – Organizational Viability

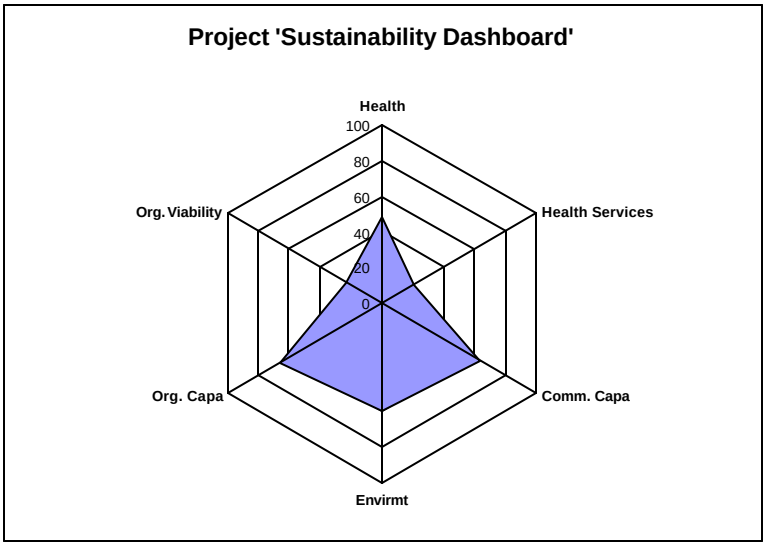
1. The board understands staff roles and responsibilities as well as the organization's finance and policies that are in place.
2. Programs are relevant to the needs of the people and are effective and reach our target population.
3. Board and staff have a monitoring plan and a training/career development plan which provides opportunities for mutual training.

Component 5 – Community Competence/Capacity

1. All members are saving regularly and this is managed by the group independently and group can correct problems independently.
2. 5 members make the plan, keep writing the plan, and follow it with all group members' participation.
3. Members independently follow a democratic process each year to select new leadership.
4. Members can properly write the passbooks and understand about keeping an accurate passbook.
5. Group is well respected and accepted in the society.
6. Group plays an active role in community in various govemment and NGO bodies through their intermediary group.

Component 6 – Ecological, Human, Economic, Political and Policy Environment

1. Percentage of households with access to safe and arsenic free water from piped water source or covered well within 15 minutes walking distance.
2. Proportion of household with access to sanitary latrines.
3. Government, NGOs and other CBOs are interested to help the health services program.
4. Government policy is very helpful for the organization.



Annex 5

Focus Group Discussion Questionnaires

Topics	Key Concept	Guide Questions
1.Role of values in health	a) Understanding and awareness of values in everyday life b) Perception of the way values affect their health behavior	**Can you describe what you understand by the term "values"?** **How do your values affect your everyday decisions?** **What are some examples of how your values affect your decision-making when…your child is sick? ….you are sick?**
2. Importance of equality to health	a) Perceived differences between girls and boys b) Health behaviors related to gender	**Do families prefer to have a boy or a girl baby? Why?** **What differences are there between the opportunities that boys and girls have?** **Are boy and girl children provided different levels of care when sick or the same? Why?**
3. Role of integrity on health	a)Relationship between the service providers and recipients b) Integrity among the family members receiving health services	**Whose cooperation do you receive during sickness, and what types of initiative do you take?** **Whose opinion do you get in receiving health services during sickness of your child?**
4. Knowledge on health	a) Health behavior for family members b) Concept on family member's health c) Concept on heath service providers	**What do you do for good health of your family members?** **What do you do for good health of pregnant women?** **What should be done for good health of your family members?** **What are the health service providers in your area and what are their services?**
5. Justice	a) Knowledge on adolescent marriage b) Knowledge on equitable distribution of health services between poor and rich	**Whose opinion gets priority during marriage of family members?** **Please mention the existing roles and regulations on marriage in Bangladesh.** **Can you mention the problems may arise due to early marriage?** **Do you think that there is any discrimination of receiving health services between poor and rich?**
6. Responsibility	a) Responsibility of family members in receiving health services	**How do family members cooperate with one another during sickness?**

Annex 6

CRWRC – BANGLADESH

Child Survival Sustainability Workshop

BRAC Inn Centre, Mohakhali, Dhaka
21-23 August 2005

List of Participants

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40	Mr. Ed Scott	
41	Mr. Zahangir Alam, BCM	Bengalcreative@aol.com
42	S.K Nandi -The Salvation Army	chdp@ban.salvationarmy.org

Annex 7

Dear CS Headquarter Technical Backstops for all CSHGP Grants:

Until further notice, USAID/Bureau for Global Health/Office of Health, Infectious Diseases and Nutrition (GH/HIDN) recommends **temporary suspension** of procurement of zinc sulfate supplements using U.S. Government funds. The waiver established in 2004 allowing CSHGP grantees to purchase and procure zinc supplements from Nutriset with USAID funds is now on **hold**.

BACKGROUND: Zinc sulfate supplementation has been demonstrated in controlled clinical trials to significantly reduce the severity and duration of dehydrating diarrheal episodes in young children. It also has longer term benefit to these children in reducing severe illnesses in the period after treatment. For these reasons, WHO and UNICEF have given policy endorsement to the use of zinc supplementation as an important adjunctive therapy to combine with Oral Rehydration Therapy (ORT) in treatment of child diarrhea.

To help support the introduction of zinc therapy, last year GH/HIDN developed a waiver for the CSHGP grantees for the purchase of zinc sulfate tablets from Nutriset, based on Nutriset's production of zinc supplement for WHO clinical trials. Since then, as stipulated in the waiver, GH/HIDN has been working with the U.S. Pharmacopoeia and UNICEF to assess Nutriset and other manufacturers as potential suppliers of high quality zinc sulfate products for large scale programmatic usage. In that process, UNICEF has determined that safety and effectiveness can best be assured by using Good Manufacturing Practices (GMP) standards for pharmaceuticals, rather than the GMP standards for nutritional supplements.

GH/HIDN has been conducting meetings regarding USAID procurement regulations which establish that products purchased using U.S. Government funds should be approved by FDA or another USAID-recognized regulatory body, such as UNICEF or WHO (pre-qualification process). In order to launch programs that are less controlled than the research trials that have been conducted, safety and effectiveness can best be assured by following pharmaceutical Good Manufacturing Practices (GMP) standards, rather than the GMP standards for nutritional supplements. For those reasons, USAID has **temporarily** suspended procurement of zinc supplements **from any source** (including Nutriset) until manufacturers have been identified as meeting pharmaceutical GMP standards.

This finding does not mean that any problems exist with the existing Nutriset zinc supplement, and there have been no cases of any adverse outcome associated with its use. However, strictly as a precautionary measure, GH/HIDN recommends suspension of procurement of zinc supplements from any source until manufacturers have been identified as meeting pharmaceutical GMP standards.

Several manufacturers, including Nutriset, are working with UNICEF and USP to upgrade their manufacturing processes to this level. It is expected that this will be achieved, and zinc sulfate product that meets this GMP standard will be produced, within five months or less. GH/HIDN will work closely with USP and UNICEF and will advise missions and grantees immediately of appropriate suppliers as soon as they are established.

We expect this delay to be short and are committed to working with our grantees to introduce zinc treatment as part of global efforts to revitalize the management of childhood diarrheal illness. Please contact Jill Boezwinkle (jboezwinkle@usaid.gov) or Namita Agravat (nagravat@usaid.gov) if you have any questions about this notice.

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Annex 8

Budget is attached separately in an Excel document.

BUDGET NARRATIVE

Revised version submitted September 23, 2005

In August 2005, CRWRC finished negotiating its revised indirect cost rate agreement with USAID's Office of Acquisition and Assistance (OAA). On August 12, CRWRC's Grants Officer notified Susan Youll of the new rate. Ms. Youll said that she would submit a request to OAA to amend the CRWRC cooperative agreement to reflect the change in the new NICRA and that this change should be expected in early October 2005. CRWRC's indirect cost rate is now 9.89%.

Personnel

Field Personnel Costs:
Program Manager @ $42,000 salary X 1.0 FTE = $42,000
Program Officer* @ $21,000 salary X 0.15 FTE = $3,150
Program Officer @ $5,500 salary X 1.0 FTE = $5,500
Monitoring/Evaluation Specialist* @ $21,000 salary X 0.10 FTE = $2,100
Administrative Assistant @ $2,500 salary X 0.5 FTE = $2,600
Accountant @ $6,000 salary X 1.0 FTE = $3,000

Headquarters Personnel Costs:
Technical Backstop for Health Programs @ $50,000 salary X 0.6 FTE = $30,000

* A change from the original proposal is that one of the key personnel, who is serving as a Program Officer and M&E Specialist, will reduce her total level of effort from 50% to 25%. Based on two quarters of activity and more detailed activity planning, it was determined that this would be sufficient to meet the objectives of the program.

Personnel costs will increase approximately 4% each year of the project to account for cost of living and merit increases. Salaries for the national-level program officer and the accountant have been increased for years two through five because actual salaries required to hire qualified staff turned out to be higher than anticipated.

Key personnel for this project will be:
- Nancy Ten Broek, Program Manager
- Kohima Daring, Monitoring and Evaluations Specialist and Program Officer
- William Story, Technical Backstop for Health Programs

Fringe Benefits
For international tier (expatriate) and home office staff, fringe benefits are calculated as 34% of an individual's gross salary. This includes:
- Health insurance (16.7%)
- Life insurance (0.38%)

- Retirement (9%)
- FICA (7.65%)
- Long-term disability (0.249%)

Expenses for vacation and sick leave are included in the salary each of these employees receives. In addition to these benefits, CRWRC covers housing costs for three international field staff. The annual housing costs ($12,000) multiplied by the level of effort these three staff will contribute to the program (57%) equals $6,840. This cost will increase slightly over the life of the project as rent prices increase. CRWRC will cover all of these housing costs with its own private resources.

National staff involved in the project will include an administrative assistance/bookkeeper, an accountant and a health consultant. The CRWRC Bangladesh salary package for nationals includes 15 days of vacation and 12 days of sick leave, which can be accrued for two years. It also includes a provident fund (10% of back salary from employee and 10% from organization), a yearly submission to a gratuity fund and five days of emergency leave per year. Together, these benefits equal approximately 18% of each staff person's salary.

Travel

Travel In-Country
Travel within Bangladesh is broken down into the categories of transport/fuel, meals, and lodging. Transport is estimated at $1,250 per year, based on the experience of CRWRC/Bangladesh staff and projected fuel costs. Per diem rates, which cover meals but not transport and lodging, have been set at $5 per day. The amounts budgeted for per diems (meals) and lodging are based on an estimate of 15 days of travel per month (total for all project staff). Rates have been set based on the many years of experience CRWRC field staff have traveling to the program sites included in this proposal.

Domestic Travel
The Technical Backstop for Health Programs will travel four times per year to participate in meetings for CORE Group, attend technical trainings, and to receive technical assistance from CSTS+. It is estimated that each trip will cost $953, based on $350 for airfare to Washington DC, $450 ($150 per night) for hotel, and $153 in meals and incidentals ($51 per day). The budget for year one is slightly lower due to the fact that the backstop was not hired until midway through the first year.

International Travel
During years two and five of the program, CRWRC will undertake midterm and final evaluations of the Child Survival and Health program. It is estimated that one CRWRC staff and one consultant will need to travel internationally to participate in each of these evaluations. International travel costs for each evaluation will include:
Airfare from Grand Rapids, MI (or other location) to Dhaka, Bangladesh @ $1,500 per person X 2 tickets= $3,000
Lodging @ $55 per night X 7 nights X 2 people = $770
Meals @ $30 per day X 7 days X 2 people = $420

$5,500 has been budgeted for year one to cover the costs of the Program Manager and Program Officer to travel to Mini-University from Bangladesh.
Airfare from Dhaka, Bangladesh to Washington, DC @ $1,500 per person X 2 tickets= $3,000
Lodging @ $150 per night X 7 nights X 2 people = $2,100
Meals @ $25 per day X 8 days X 2 people = $400

Another $6,000 per year for years 2-5 of the project has been budgeted for international travel to cover the costs of consultation between the Technical Backstop and the Program Manager. It is anticipated that these funds will cover two trips per year, based on the calculations provided above. These calculations are based on the experience of CRWRC staff who travel frequently between Bangladesh and the United States.

As part of the organizational development component of the program, CRWRC will encourage its staff and partners from other fields to visit Bangladesh to learn from the health program in progress there. The cost per person is estimated at $1,500, based on CRWRC's past experience with conducting exchange visits with staff. CRWRC anticipates sending a group of four to visit the program site in Bangladesh each year, except year one, at a total cost of $6,000 per year. CRWRC will cover $750 of this cost each year with its own staff training money.

Supplies
Four laptops will be purchased for the project at $1,600 each. One will be needed by the Program Manager, and one will be needed by each of the Health Coordinators at the implementing partner organizations: Sathi, Supoth, and Pari.

Most supplies for the program are included under sub-grants to local NGO partners (see below). Health education training materials are included in the contractual fees that will be paid to Joyramkura and Lamb.

Zinc supplements will no longer be purchased for treatment of diarrhea and ARI in CRWRC program areas. CRWRC will incorporate health messages about zinc in their C-IMCI strategy. The money designated for zinc supplements will be redistributed into zinc operations research, zinc training, travel (domestic and international) and health education with Global Learning Partners.

There are other necessary supplies not included in the budget because they will be contributed by the participating thana federations. Encouraging the local people to invest in their own health is an important component of building local ownership and sustainability. Each of the nine thana federations will purchase a TALC self-monitoring scale at a cost of $9. They will also purchase a total of 500 latrines per year at a cost of $15 each, amounting to a local contribution of $7,500 per year.

Contractual
CRWRC will sub-contract with LAMB Community Health Program, Joyramkura Health Care Project, and Radda Barnen to provide training services to traditional birth attendants (TBAs) and

community health volunteers (CHVs). These training costs listed in the tables below are based on quotes received from the contractors.

Lamb Community Health Program		Target area served by: **Supoth**		
YR	Activities	# Participants	Cost/Participant ($)	Total Cost ($)
1	TBAs training	30	100	3000
1	CHV training	25	100	2500
2	TBAs training follow-up	30	68.75	2062
2	TBAs refresher course	25	68.75	1719
2	CHV training	25	68.75	1719
3	CHV training	35	47.82	1674
3	TBA Follow-up	60	47.82	2869
3	TBA training	20	47.82	957
4	TBA Follow-up	75	52.38	3928
4	CHV training	30	52.38	1572
5	TBA follow-up	75	20.51	1538
5	CHV follow-up	120	20.91	2462
Tot.				$26,000

Joyramkura		Target area served by: **Pari**		
YR	Activities	# Participants	Cost/Participant ($)	Total Cost ($)
1	TBA Training	25	91.66	2292
1	CHV Training	35	91.66	3208
2	TBA Training	25	50	1250
2	Refresher course	25	50	1250
2	CHV Training	60	50	3000
3	TBA Training	25	40.75	1019
3	Refresher course	25	40.75	1019
3	CHV Training	60	40.75	2445
3	TBA Seminar	25	40.75	1017
4	TBA Refresher course	25	32.52	813
4	TBA Seminar	50	32.52	1626
4	CHV Training	48	32.52	1561
5	TBA Seminar	75	40	3000
Tot.				$23,500

Radda Barnen		Target area served by: **Sathi**		
YR	Activities	# Participants	Cost/Participant ($)	Total Cost ($)
1	TBA Training	25	100	2500
1	CHV Training	35	100	3500
2	TBA Training	25	54.55	1364
2	Refresher Course	25	54.55	1364
2	CHV Training	60	54.55	3272
3	TBA Training	25	44.45	1111
3	TBA Seminar	25	44.45	1111

3	Refresher Course	25	44.45	1111
3	CHV Training	60	44.45	2667
4	TBA Refresher Course	25	32.52	813
4	TBA Seminar	50	32.52	1626
4	CHV Training	48	32.52	1561
5	TBA Seminar	75	53.33	4000
Tot.				$26,000

CRWRC will also sub-contract with Bengal Creative Media to conduct education campaigns using drama. These campaigns will address cultural resistance to new birthing practices used by trained traditional birth attendants. BCM has a signed contract with CRWRC to provide three workshops each year for the first three years of the project. Each workshop will reach 30 participants, or 180 total over the life of the project. BCM will develop one new script for each year of the program. Costs decline between the first year and third year because there are higher costs as the beginning while scripts are in development.

CRWRC will also contract with Global Learning Partners (GLP) to provide training for trainers in methods of adult dialogue education. Fifteen project staff will participate: five from each partner. A draft proposal from Global Partners is currently under negotiation. Final decisions about which training components will be offered depend on the results of a learning needs assessment of the staff that we will be done in year one. GLP will also be contracted to assist CRWRC in the creation of quality, integrated C-IMCI health messages in year three.

CRWRC will contract with HEED Bangladesh to conduct an arsenic assessment in year one. Based on estimates provided by HEED, we anticipate spending up to $200 for this arsenic testing. This is a change from the original proposal. Originally $1,000 per year was budgeted for arsenic testing, but arsenic interventions were dropped from our detailed implementation plan, so the budget has been revised accordingly.

No U.S.-based consultants will be hired for this project.

Other Direct Costs

Sub-grants to local NGO partners:
CRWRC used the following criteria to select local NGO partners for this project:

- Recognition and approval from the Government of Bangladesh
- Active partnership agreement with CRWRC
- Good performance record of achieving planned outcomes and managing finances
- Mission and mandate prioritizing health promotion in poor communities
- Strong operational presence in communities where there is a compelling need for improved health and survival rates among mothers and children under five
- Experience implementing health programs and interest in increasing organizational capacity for doing effective health interventions
- Expertise in establishing community groups/people's organizations and building community capacity for addressing poverty, disease, and injustice
- Interest in participating in the Child Survival and Health project

CRWRC personnel in Bangladesh discussed sub-recipient opportunities for this project with various potential partners before submitting an application to USAID. Staff from CRWRC/Bangladesh have worked with them to develop appropriate budgets for the project. Based on past experience collaborating with these organizations, CRWRC is confident that they are able to implement the activities outlined in this application in a timely and cost-effective manner.

Each of the partner organizations—Pari, Sathi, and Supoth—will receive a sub-grant of $23,000 per year to cover costs of implementing the Child Survival and Health Program:

- $2,000 for Directors salary (10% effort)
- $3,000 for Health Coordinator's salary (100% effort)
- $8,000 for salaries of 4-6 other health staff
- $4,500 for training materials and flip charts, health supplies (vitamin A capsules, ORS packets, iodized oil and salt, Road to Health cards, and Maternal Health cards), as well baseline surveys and ongoing monitoring of program performance
- $1,500 for nutrition surveillance (in collaboration with other organizations)
- $2,000 for staff travel to program sites and trainings
- $2,000 for administration and office supplies

CRWRC will provide additional sub-grant funding to Sathi in the amount of $11,500 per year from its own private resources in order to support additional programming that reinforces the effectiveness of the health interventions in this program through group formation and developing capacity at the primary group and federation.

Monitoring and Evaluation
Funds have been budgeted for years three and five to cover costs of midterm and final program evaluations. This money will be used to hire an outside consultant to assist in the midterm and final evaluations in years 3 and 5.

Zinc Training
During year two, CRWRC will hold three workshops on the benefits of zinc supplementation for treating and preventing diarrhea and ARI. These workshops will be held in each program area and will include project staff, private practitioners, village doctors, pharmacists, and CHVs. Participants on these workshops will be encouraged to promote the use of locally approved zinc supplements in their working areas. This addition is reflected in the budget.

Zinc Research
During years one and two of the project, CRWRC will investigate the impact of zinc supplementation on reduction of morbidity due to diarrhea and acute respiratory infections in children who are 23-47 months of age. The total budget for this operational research will be $16,620. Details about how this amount was estimated are provided in the following table.

Budget (without personnel cost)

A)	*Supplies and materials*			
1.	Refrigerator (n=1)			500
2.	Centrifuge machine (n=1)			150
3.	Test tube/Racks/Cold chain bag			1000
3.	Deworming tablet	2400 pcs.		200
4.	Zinc tablet	For 600 subjects		200
5.	Office supplies and stationeries and questionnaires			750
Sub-total				*2,050*
B)	*Equipment and Investigation*			
1.	Weighing scale (digital)	8pcs.		250
2.	Height board	8pcs		700
3.	Serum zinc assay	2400 samples each @ 4.5$ (1200 at baseline + 1200 at endline+35 QC)		10,870
C)	Transport/conveyance	Dhaka-Netrokona-Dhaka (Sample transportation/once per week, field visit)		1,000
D)	Data Management			500
E)	Miscellaneous			500
Sub-total				*13,820*
Grand-total				**16,620**

Nutritional Surveillance
To conduct additional nutrition surveillance in collaboration with other organizations operating in the program target areas, $1,500 has been budgeted for year one and an additional $2,000 per year for years two through five.

Learning Circle Events
The Learning Circle is a forum of 14 NGOs convened by CRWRC for learning and networking. At quarterly meetings, CRWRC will hire training organizations to provide instruction in health interventions to be determined by member organizations. CRWRC estimates that $1,500 will be required to provide training at each quarterly meeting, for a total cost of $6,000 per year. This cost will include fees to the training organizations as well as materials.

Behavior Change Communication Trainings
CRWRC will train personnel from the partner organizations in the BEHAVE Framework. Trainings will be offered during years 2 and 3 of the project. Funds are budgeted to bring in a CRWRC staff person who is trained in the BEHAVE Framework to lead the 5 day training. Airfare, hotel, and meals for trainer will cost approximately $1,500. (This figure is based on CRWRC staff experience traveling to Bangladesh). Training cost per participant include the costs of the training center, meals, materials, accommodations and transportation to the training center. This is estimated to be $100 per person for 25 participants, or $2,500.

Field Office Expenses
Administrative/office and vehicle expenses for CRWRC's field office in Bangladesh represent the percentage of time that the office will be devoted to work on the proposed program only. CRWRC will pay for these direct project costs out its own private resources. The amount for year one was increased by $1,625 to accommodate the higher administrative costs associated with hiring new staff, conducting the baseline survey, and developing the Detailed Implementation Plan.

Indirect Costs

In 1999, when CRWRC last had a cooperative agreement from USAID/HQ, the Negotiated Indirect Cost Rate was 13.9%. CRWRC has prepared and submitted a new indirect cost rate proposal that is still under negotiation. CRWRC's new NICRA is likely to be much closer to 11% than to 13.9%, so the budget has been revised based on that rate. Funds that would have contributed to NICRA have been allocated to the following lines:

- Salaries for field-based personnel,
- International travel to Mini-University,
- Zinc research and zinc trainings, and
- Training staff of local partner organizations in Behavior Change Communication.

Annex 9

Project-Wide Monitoring and Evaluation Plan

BOLD = KPC Rapid CATCH Indicators

Intervention areas	***Indicators***	***Panchagar***	***Netrokona***	***Dhaka***
Strategic Objective I. Improve Maternal and Neonatal Care				
Delivery by Skilled Health Personnel (including TTBAs)	Percentage of children aged 0-23 months whose births were attended by skilled health personnel	Numerator: 26 Denominator: 147 Percentage: 18% Confidence Interval: ± Change at EOP: 30%	Numerator: 32 Denominator: 150 Percentage: 21% Confidence Interval: ± Change at EOP: 29%	Numerator: 53 Denominator: 150 Percentage: 35% Confidence Interval: ± Change at EOP: 50%
Prenatal Care Coverage	Percentage of mothers who had at least one prenatal visit prior to the birth of her youngest child less than 24 months of age	Numerator: 89 Denominator: 147 Percentage: 60% Confidence Interval: ± Change at EOP: 60%	Numerator: 74 Denominator: 150 Percentage: 49% Confidence Interval: ± Change at EOP: 24%	Numerator: 126 Denominator: 148 Percentage: 85 Confidence Interval: ± Change at EOP: 51%
Tetanus Toxoid (TT)	**Percentage of mothers who received at least two tetanus toxoid injections before the birth of the youngest child less than 24 months of age**	**Numerator: 100** **Denominator: 125** **Percentage: 80%** **Confidence Interval:** ± **17.2%** **Change at EOP: 18%**	**Numerator: 92** **Denominator: 149** **Percentage: 62%** **Confidence Interval:** ± **14.8%** **Change at EOP: 23%**	**Numerator: 88** **Denominator: 150** **Percentage: 59%** **Confidence Interval:** ± **14.6%** **Change at EOP: 26%**
Knowledge on Maternal Danger Signs/Symptoms	Percent of mothers of children age 0-23 months able to report at least two known maternal danger signs/symptoms during the prenatal, natal and postnatal period	Numerator: 50 Denominator: 150 Percentage: 33% Confidence Interval: ± Change at EOP: 25%	Numerator: 47 Denominator: 150 Percentage: 31% Confidence Interval: ± Change at EOP: 24%	Numerator: 56 Denominator: 150 Percentage: 37% Confidence Interval: ± Change at EOP: 45%

Intervention areas	*Indicators*	*Panchagar*	*Netrokona*	*Dhaka*
Strategic Objective II. Prevent and Properly Treat Diarrheal Disease				
ORT Use During Diarrheal Episode	Percentage of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids (RHF)	Numerator: 9 Denominator: 14 Percentage: 64% Confidence Interval: ± Change at EOP: 20%	Numerator: 25 Denominator: 5 Percentage: 56% Confidence Interval: ± Change at EOP: 19%	Numerator: 6 Denominator: 11 Percentage: 55% Confidence Interval: ± Change at EOP: 25%
Increased Fluid and Continued Feeding During a Diarrheal Episode*	**Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered more fluids AND the same amount or more food during the diarrheal episode**	**Numerator: 1** **Denominator: 14** **Percentage: 7%** **Confidence Interval: ± 19.4%** **Change at EOP: 30%**	**Numerator: 3** **Denominator: 44** **Percentage: 7%** **Confidence Interval: ± 10.7%** **Change at EOP: 32%**	**Numerator: 3** **Denominator: 11** **Percentage: 27%** **Confidence Interval: ± 40.6%** **Change at EOP: 31%**
		Project-wide Estimate = 12%		
Zinc Supplementation During Diarrheal Episode	Percentage of children aged 0-23 months with diarrhea in the last two weeks who received recommended oral zinc therapy during the illness	Numerator: 2 Denominator: 14 Percentage: 14% Confidence Interval: ± Change at EOP: 65%	Numerator: 5 Denominator: 46 Percentage: 11% Confidence Interval: ± Change at EOP: 79%	Numerator: 1 Denominator: 11 Percentage: 9% Confidence Interval: ± Change at EOP: 81%
Availability of Soap for Hand Washing	**Percentage of mothers of children age 0-23 months that have soap readily available for hand washing**	**Numerator: 80** **Denominator: 150** **Percentage: 53%** **Confidence Interval: ± 14.2%** **Change at EOP: 20%**	**Numerator: 22** **Denominator: 150** **Percentage: 15%** **Confidence Interval: ± 8.3%** **Change at EOP: 40%**	**Numerator: 56** **Denominator: 150** **Percentage: 37%** **Confidence Interval: ± 12.5%** **Change at EOP: 43%**

*This indicator will be changed at the midterm and final survey to measure increased fluid and continued feeding during *any* illness, not just diarrhea.

Intervention areas	*Indicators*	*Panchagar*	*Netrokona*	*Dhaka*
Strategic Objective III. Detect ARI and Make Appropriate Referrals				
ARI Care Seeking	Percentage of children aged 0-23 months with fast or difficult breathing and/or cough in the last two weeks who were taken to a health facility	Numerator: 15 Denominator: 51 Percentage: 29% Confidence Interval: ± Change at EOP: 30%	Numerator: 1 Denominator: 13 Percentage: 8% Confidence Interval: ± Change at EOP: 25%	Numerator: 3 Denominator: 8 Percentage: 63% Confidence Interval: ± Change at EOP: 27%
		Project-wide Estimate = 27%		
Maternal Knowledge of Child Danger Signs/ Symptoms	**Percentage of mothers of children age 0-23 months who report at least two of child danger signs/symptoms**	**Numerator: 105** **Denominator: 150** **Percentage: 70%** **Confidence Interval:** ± **15.3%** **Change at EOP: 16%**	**Numerator: 109** **Denominator: 150** **Percentage: 73%** **Confidence Interval:** ± **15.4%** **Change at EOP: 17%**	**Numerator: 93** **Denominator: 150** **Percentage: 62%** **Confidence Interval:** ± **14.8%** **Change at EOP: 28%**

Intervention areas	*Indicators*	*Panchagar*	*Netrokona*	*Dhaka*
Strategic Objective IV. Improve Child Nutrition				
Underweight	**Percentage of children aged 0-23 months who are more than 2 standard deviations (SD) below the median weight-for-age (WA) of the WHO/NCHS reference population**	**Numerator: 57 Denominator: 150 Percentage: 38% Confidence Interval: ± 12.6% Change at EOP: 18%**	**Numerator: 61 Denominator: 150 Percentage: 41% Confidence Interval: ± 12.9% Change at EOP: 21%**	**Numerator: 58 Denominator: 150 Percentage: 39% Confidence Interval: ± 12.6% Change at EOP: 19%**
Exclusive Breastfeeding	**Percentage of children aged 0-5 months who were fed breast milk only in the last 24 hours**	**Numerator: 29 Denominator: 33 Percentage: 88% Confidence Interval: ± 33.9% Change at EOP: 8%**	**Numerator: 34 Denominator: 46 Percentage: 74% Confidence Interval: ± 27.9% Change at EOP: 11%**	**Numerator: 34 Denominator: 53 Percentage: 64% Confidence Interval: ± 25.1% Change at EOP: 26%**
		Project-wide Estimate = 74%		
Appropriate Complementary Feeding Practice	**Percentage of infants aged 6-9 months who received semi-solid or family foods in the last 24 hours**	**Numerator: 4 Denominator: 15 Percentage: 27% Confidence Interval: ± 34.4% Change at EOP: 30%**	**Numerator: 2 Denominator: 14 Percentage: 14% Confidence Interval: ± 27.0% Change at EOP: 16%**	**Numerator: 11 Denominator: 20 Percentage: 55% Confidence Interval: ± 39.1% Change at EOP: 20%**
		Project-wide Estimate = 28%		
Vitamin A Coverage	Percentage children aged 6-23 months who received a Vitamin A dose in the past six months	Numerator: 73 Denominator: 117 Percentage: 62% Confidence Interval: ± Change at EOP: 30%	Numerator: 63 Denominator: 104 Percentage:61% Confidence Interval: ± Change at EOP: 14%	Numerator: 51 Denominator: 97 Percentage: 53% Confidence Interval: ± Change at EOP: 27%

Intervention areas	*Indicators*	*Panchagar*	*Netrokona*	*Dhaka*
Strategic Objective V. Reduce Morbidity and Mortality from Vaccine Preventable Diseases				
Complete Immunization Coverage	**Percentage of children under 12 months fully immunized with 1 dose each of BCG and measles and 3 doses each of DPT and Polio**	**Numerator: 42 Denominator: 74 Percentage: 57% Confidence Interval: ± 20.5% Change at EOP: 30%**	**Numerator: 21 Denominator: 66 Percentage: 32% Confidence Interval: ± 17.6% Change at EOP: 38%**	**Numerator: 15 Denominator: 54 Percentage: 28% Confidence Interval: ± 18.4% Change at EOP: 52%**
		Project-wide Estimate = 36%		
Strategic Objective VI. Increase Awareness of HIV/AIDS				
Maternal Knowledge of HIV Risk Reduction	**Percentage of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving prevention of HIV**	**Numerator: 18 Denominator: 150 Percentage: 12% Confidence Interval: ± 7.6% Change at EOP: 25%**	**Numerator: 20 Denominator: 150 Percentage: 13% Confidence Interval: ± 8.0% Change at EOP: 26%**	**Numerator: 76 Denominator: 150 Percentage: 51% Confidence Interval: ± 13.9% Change at EOP: 45%**

Annex 10

Abstract

Comparison of Health and Nutritional Status between Tribal and Bengali Children Aged 0-23 Months in Rural Bangladesh

N.R. Sarkar[1], N.L. TenBroek[1], K. Daring[1] and W. Story[2]

Background: Approximately 10% of the populations in Durgapur and Kalmakanda Upazilas in Netrokona district are Tribal. No information on health and nutritional status of children is available comparing between Tribal and Bengali populations.

Objective: Comparing the health and nutritional status, feeding practices of children, and nutritional status of mothers in Tribal and Bengali populations.

Methodology: Cross sectional study was conducted in Durgapur and Kalmakanda Upazilas in Netrokona district during December 2004-January 2005. Fifty-seven pairs of Tribal and 243 pairs of Bengali mothers and children aged 0-23 months were studied. Feeding practices of children, their morbidity, race, socioeconomic status and maternal educational level were recorded. Weight and length/height of mothers and children were measured.

Results: Prevalence of underweight and stunted children was significantly lower in Tribal populations as compared to Bengali populations (29% vs. 51%, P=0.006 and 25% vs. 54%, P<0.001 respectively), but wasting was comparable (14% vs. 19%, P=0.430). Greater percentage of mothers in Bengali group was suffering from undernutrition compared to Tribal (55% vs. 21%, P<0.001). Introduction of pre-lacteal feeding was significantly lower in tribal children compared to Bengali (49% vs. 74%, P=<0.001). Continuation of exclusive breastfeeding up to 6 months and introduction of appropriate complementary feeding at age between 6-8 months were found significantly higher in Tribal children compared to Bengali (68% vs. 35%, P<0.001 and 30% vs. 3%, P=0.036 respectively). A significantly higher proportion of Bengali children were suffering from lower respiratory infections (LRI) compared to Tribal (12% vs. 2%, p=0.023). The prevalence of diarrhea was comparable between the two groups (25% vs. 28%, p=0.598). Multivariate regression analysis reveled that Bengali children were two times more likely to be underweight (OR=2.00, 95% CI= 1.04-3.83) compared to Tribal, and children of undernourished and illiterate mothers were at more risk of being underweight than children of well-nourished and literate mothers (OR=1.69, 95%CI=1.04-2.75 and OR=1.87, 95%CI=1.16-2.99 respectively).

Conclusion: Tribal children and mothers are nutritionally better off than Bengali children and mothers. Comparatively appropriate feeding practices and lower prevalence of LRI have been observed in Tribal children. Maternal under nutrition and illiteracy are the risk factors of low weight in these children.

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Key words: Tribal, health and nutritional status, children, diarrhea and lower respiratory infections.

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Annex 11

The Role of Community Values in Assessing Child Survival Sustainability

Learning Objectives
By the end of my presentation, the participants will be able to explain the role of values in child survival sustainability, identify core values related to health in Bangladesh, and realize the importance of community values in assessing sustainability.

Background
As part of a technical assistance grant from the US Agency for International Development (USAID) and the Child Survival Technical Support Plus (CSTS+) Project, the Christian Reformed World Relief Committee (CRWRC) and its partner organizations implemented the Child Survival Sustainability Assessment (CSSA) for their child survival projects in three regions of Bangladesh impacting the health of over 10,000 mothers and children over the next five years. While applying the CSSA, CRWRC realized the need to incorporate the community's core values and beliefs into the framework. This presentation will explain the process CRWRC used to analyze the role of core values in sustainable health and the preliminary results from a community assessment of values.

Design/Methods
CRWRC facilitated two participatory workshops on the CSSA and the role of values in child survival sustainability in June 2005 with 34 local partner staff and in August 2005 with 40 local stakeholders. Also in June 2005, CRWRC partners assessed values in the communities in which they work by interviewing 561 people using Focus Group Discussion (FGD) methodology. During this time, CRWRC researched the role of values in health behavior theory and sustainability assessment.

Results/Outcome
CRWRC and its partners created the following list of values that are critical to child survival sustainability in Bangladesh: knowledge, respect, service, responsibility, equality, honesty, unity, justice and self-confidence. CRWRC partners used this list to create FGD questions, which revealed that the values of justice and equality may be distorted in certain communities. This has led to health care discrimination based on gender, race, and socioeconomic status. According to value-expectancy theories, if positive values are distorted or a community embraces values that prevent positive change, then positive health outcomes will be difficult to sustain.

Conclusions
In order to predict the sustainability of positive health outcomes, values must be assessed within a community. This assessment can be used for three purposes: 1) to serve as a gauge of the values that exist in a community which promote child survival sustainability; 2) to help inform culturally sensitive child survival interventions; and 3) to celebrate values that promote sustainable health and challenge values that prevent sustainable health. This assessment should be implemented by the community and facilitated by the organization working in the community using culturally sensitive, participatory techniques. Further research is needed in order to discover the most effective community-owned method for assessing values and measuring change.

Partners
USAID, CSTS+

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